CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV

MEDALLION 3.0

Some individuals enrolled with Medicaid (enrollees) may receive primary and acute care through Medicaid contracted managed care organizations (MCO), also known as the MEDALLION 3.0 Program. For MCO enrollees, assessment and evaluation, and outpatient psychiatric and substance abuse therapy services (individual, family, and group) are handled through the individual's MCO.

MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the enrollee's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the enrollee's MCO directly for information regarding the contractual, coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

The following community mental health and substance abuse rehabilitative services are **carved-out** of the MCO contracts and are covered through fee-for-service, including for MCO enrollees, in accordance with DMAS fee-for-service established coverage criteria and guidelines. The MCOs are responsible to cover transportation for carved-out services.

Coverage for MEDALLION 3.0 MCO Enrollees (Medicaid, FAMIS Plus and FAMIS MOMS)

Intensive In-home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Crisis Intervention
Mental Health Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance, and for Adults with Serious Mental Illness
Mental Health Day Treatment/Partial Hospitalization Services
Psychosocial Rehabilitation
Mental Health Crisis Intervention
Intensive Community Treatment
Crisis Stabilization
Mental Health Skill-building Services
Substance Abuse Crisis Intervention
Substance Abuse Intensive Outpatient Treatment
Substance Abuse Day Treatment
Opioid Treatment
Residential Substance Abuse Treatment for Pregnant and Post Partum Women
Substance Abuse Day Treatment for Pregnant and Post Partum Women
Substance Abuse Case Management
Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)

Coverage For FAMIS MCO Enrollees*

Intensive In-Home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Crisis Intervention
Mental Health Case Management for Children at Risk of Serious Emotional Disturbance
Children with Serious Emotional Disturbance

Note—No other CMHRS other than those listed above are covered by DMAS For FAMIS MCO Enrollees*

Medicaid managed care organizations receive data on the community mental health rehabilitative services utilized by their members. Providers of community mental health rehabilitative services may be contacted by the managed care organizations to discuss the care of these individuals.

COVERED SERVICES AND LIMITATIONS

Introduction

Community mental health rehabilitative services (CMHRS) are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances. Clinical treatment differs from community social assistance and/or child welfare programs in that behavioral health services are designed to provide treatment to a mental illness rather than offer assistance for hardship due to socio-economic, age, or physical disability. Information on where individuals may find assistance with personal needs, education, employment, housing, income support, meals, and other needs is available at http://www.211virginia.org.

Non-emergency transportation for the individual receiving services to medical appointments, including psychiatric appointments, must be authorized by and billed to the Medicaid transportation broker or the individual's assigned MCO and is not included as part of any CMHRS service. Individual providers and agencies may seek mileage reimbursement through the transportation broker for services under which transportation is not covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

The current transportation broker is Logisticare and can be contacted at https://member.logisticare.com or by calling the LogistiCare reservation line at 1-866-386-8331 in order to arrange transportation services and complete forms for gas reimbursement. For more information regarding time frames for making reservations please refer to the LogistiCare website (www.logisticare.com). Individuals enrolled in an MCO must contact the individual's MCO directly in order to arrange transportation.

Community Mental Health Rehabilitative Services

The behavioral health services described below are covered under the Medicaid Program. Providers of services must meet the qualifications described under "Provider Participation

Requirements" in Chapter II of this manual. Criteria for all clinical service providers must be met.

Services must be provided in conjunction with a current service specific provider intake of the individual's specific needs and in accordance with the Individualized Service Plan (ISP) developed for that individual. A physical examination is recommended as a component of the intake for all Community Mental Health Rehabilitative Services.

Community Mental Health Rehabilitative Services require an Individualized Service Plan (ISP) completed by the service specific provider. The ISP is a comprehensive and regularly updated document specific to the individual being treated containing but not necessarily limited to their treatment or training needs, goals and measurable objectives to meet the identified needs, and services to be provided with the recommended frequency to accomplish the measurable goals and objectives. The service specific provider shall include the individual in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated as the needs and progress, or lack of progress, of the individual changes.

Under the Medicaid Program, mental health clinic services are also covered. For the recognized providers of these services, a description of the services, billing procedures, and other items are included in the *Mental Health Clinic* Provider Manual issued by the Department of Medical Assistance Services (DMAS).

Medicaid enrolled individuals who are receiving Community Mental Health Rehabilitative Services may receive other Medicaid-covered services for which they qualify unless specifically prohibited as described for each service. Please note the program service matrix in the exhibits of this chapter that provides guidance regarding the provision of concurrent or overlapping services.

Independent Clinical Assessment for Children's Rehabilitative Services

Effective July 18, 2011, the Department of Medical Assistance Services (DMAS) required an independent clinical assessment as a part of the service authorization process for Medicaid and FAMIS children's community mental health rehabilitative services (CMHRS). This includes children and youth up to age 21 enrolled in Medicaid and FAMIS fee for service or managed care programs. The BHSA contracts with the local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) (herein referred to as the "independent assessor") to conduct the independent clinical assessment. The affected children's community-based mental health rehabilitative services are Intensive In-Home (IIH), Therapeutic Day Treatment (TDT), and Mental Health Skill-building Services (MHSS) for individuals up to the age of 21. Each child or youth must have an independent clinical assessment prior to the initiation of the affected services mentioned above. Children and youth who are being discharged from residential treatment (DMAS Levels A, B, or C), or from a psychiatric inpatient hospitalization do not need an independent clinical assessment to access IIH, TDT, or MHSS. They are required to have an independent clinical assessment as part of any subsequent service reauthorization. For Therapeutic Day Treatment services only, a new independent clinical assessment is not required when the individual was enrolled in TDT services at the end of one school year and will begin TDT services again with the same provider the beginning of the next school year.

An independent clinical assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for one of the affected CMHRS services for dates of service beginning on or after July 18th, 2011. New services are defined as CMHRS services for which the individual does not have a current service authorization in effect as of July 17, 2011. Independent assessors shall meet the DMAS definition of a licensed mental health professional (LMHP) including persons who have registered with the appropriate licensing board and are working toward licensure (LMHP Resident or LMHP Supervisee).

The Independent Clinical Assessment Process

1. A parent or legal guardian of a child or youth who is believed to be in need of one of the affected community-based mental health rehabilitative services must contact the local CSB/BHA to request an independent clinical assessment. If a service provider receives a request to provide one of the affected services, the service provider must refer the parent/legal guardian to the local CSB/BHA first to obtain the independent clinical assessment. The independent clinical assessment must be completed prior to service initiation. If the child or youth is in immediate need of behavioral health treatment, the independent clinical assessor will make a referral to appropriate, currently reimbursed Medicaid emergency services in accordance with 12 VAC 30-50-226 and may also contact the child or youth's MCO to alert the MCO of the child's needs with parental or guardian consent.

2. Once the CSB/BHA is contacted by the parent or legal guardian, the independent clinical assessment appointment will be offered within five (5) business days of the request for IIH Services independent clinical assessment and within ten (10) business days of the request for TDT and MHSS independent clinical assessment. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian. CSBs/BHAs will attempt to accommodate working schedules of parents and legal guardians. Medicaid transportation may be used to transport the child or youth and parent/legal guardian to the independent clinical assessment appointment.

3. The independent clinical assessor will conduct the independent clinical assessment with the child or youth and the parent or legal guardian using a standardized format and make a recommendation for the most appropriate, medically necessary services, if indicated. Only the parent or legal guardian and child or youth will be permitted in the room during the independent clinical assessment. Recommendations may include community mental health rehabilitative services, psychiatric, or outpatient behavioral health services.

4. The independent clinical assessor will inform the parent or legal guardian about the recommended behavioral health service options and their freedom of choice of providers. This discussion must be documented by the independent clinical assessor. The family or legal guardian will be asked if they have a service provider in mind for the recommended service(s). If a service provider has been identified, the independent assessor will note the choice of service provider on the Choice form. In addition, the independent assessor will ask the parent or legal guardian to sign a release of information if the parent agrees to share clinical assessment information with the chosen service provider(s). If a service provider has not been identified, the independent assessor will provide the parent or legal guardian with a provider list generated by the BHSA. For outpatient behavioral health services, the independent clinical assessor will refer the parent or legal guardian to the child or youth's MCO or the parent or guardian may contact the primary care physician.

5. The independent clinical assessor will electronically submit the independent clinical assessment summary data within one (1) business day of completing the assessment into the BHSA web portal service authorization system. The independent clinical assessment will be effective for a 30 day period from the date the assessment was completed with the child. The independent clinical assessor will complete assessment documentation within three (3) business days of the assessment.

6. If a community mental health rehabilitative service has been recommended, the parent or legal guardian may choose and contact a CMHRS service provider. Prior to the initiation of treatment, the CMHRS service provider must request a copy of the fully completed independent clinical assessment document. If the parent or legal guardian consents to the release of information, the independent clinical assessor will mail, fax or send a copy of the full independent clinical assessment to the service provider within five (5) business days of the request. The service provider (supported by the independent clinical assessment) will then conduct a service specific provider intake for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Skill-building Services (H0032, U8) and develop an initial service plan.

7. If the selected service provider concurs that the child meets criteria for the service recommended by the independent clinical assessor, the selected service provider will submit a service authorization request to Magellan. A copy of the fully completed independent clinical assessment must be in the service provider's medical record for the individual. The service provider's service specific intake for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Skill-building Services (H0032, U8) must not occur prior to the independent clinical assessment.

8. If a service provider identifies the need for additional services not included in the independent clinical assessment that is clinically indicated due to a significant change in the child's life that occurred after the independent clinical assessment, the service provider must contact the independent clinical assessor and request a modification within thirty (30) days of the completion of the independent clinical assessment. If the independent clinical assessment is greater than thirty (30) days old, another independent clinical assessment must be obtained prior to the initiation of a new CMHRS service. Examples of a significant change include hospitalization; school suspension or expulsion; death of a family member living in the household; or hospitalization or incarceration of a parent/legal guardian.

COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES

The following behavioral health services are covered under the Medicaid Program. Carefully read the criteria, service definitions, and maximum service limits in the discussion of each service.

Service limitations are counted from the first date-of-service billed. The fiscal year period for the start up of this process will be July 1 through June 30.

Services are delivered to specific populations based on the behavioral health needs of each individual.

For services that require service authorization, the service specific provider intake to determine specific medically necessity interventions may be billed using the designated service specific provider intake procedure code and modifier (if needed). If there is a lapse in service for more than 30 consecutive calendar days the reason for the lapse and the rationale for the continued need for the service must be documented. The ISP must be reviewed and updated to determine if there are changes, and signed by the individual and/or family. If the provider feels a more comprehensive service specific provider intake is needed and there are additional service specific provider intakes available for the fiscal year, they may choose to complete a comprehensive service specific provider intake and bill the appropriate service specific provider intake code that corresponds to the service/treatment. Please refer to Chapter V of this manual for service specific provider intake billing codes and instructions. Providers should follow their agency's policies regarding discharge procedures.

Service Authorization is required for the following services:

- Intensive In-Home (H2012)
- Community Residential Treatment, Level A (H2022 HW (CSA) H2022 HK (non CSA)
- Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) H2020 HK (non-CSA)
- Therapeutic Day Treatment for Children up to age 21 (H0035)
- Day Treatment / Partial Hospitalization (H0035)
- Intensive Community Treatment (H0039)
- Psychosocial Rehabilitation (H2017)
- Mental Health Skill-building Services (H0046)

Community Mental Health Rehabilitation Services that do not require a service authorization may require registration with the BHSA. Mental Health Case Management (H0023) requires a Registration effective December 1, 2013. Crisis Intervention (H0036) and Crisis Stabilization (H2019) require registration effective April 1, 2014. Providers should contact the BHSA directly for information about registrations

<u>The Service Authorization and Registration processes are described in Appendix C of this manual.</u>

For those services not requiring service authorization the provider of choice may bill for an intake even if the individual is found ineligible for the service, as long as clear documentation of this activity is provided and the service specific provider intake time duration is recorded and all service specific provider intake requirements are met and documented.

For all community mental health rehabilitative services that allow concurrent provision of case management, the service provider **must** collaborate with the case manager and primary care physician and provide notification of the provision of services. In addition, the provider **must** send written monthly updates to the case manager. A discharge summary **must** be sent to the case manager within 30 calendar days of the service discontinuation date. Case management may be provided through one of the following: Intensive In-Home services, Intensive Community Treatment, Treatment Foster Care Case Management,

mental health or developmental disability case management from a Community Service Board (CSB) or Behavioral Health Authority (BHA), substance abuse case management, or case management for individuals with developmental disabilities who are eligible for or receiving services through the Individual and Family Developmental Disabilities Support Waiver. Only one type of case management may be provided at a time.

Providers of all community mental health and substance abuse services are required to adhere to DMAS marketing requirements. Please see Appendix D for details on these requirements.

SERVICE CRITERIA AND DEFINITIONS - EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) FOR INDIVIDUALS UNDER THE AGE OF 21

Intensive In-Home Services (IIH) for Children and Adolescents (H2012)

Service Definition

IIH services for Children/Adolescents under age 21 are intensive, time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to documented clinical needs of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g. counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response.

Providers need to ensure that these services focus on the mental health needs of the child and not the social or economic issues of the household. Clinical treatment differs from community social assistance and/or child welfare programs in that mental health services are designed to treat a mental illness rather than offer assistance for hardship due to socio-economic, age, or physical disability. Information on where individuals may find assistance with personal needs, education, employment, housing, income support, meals, and other needs is available at http://www.211virginia.org.

Home is defined as the family residence and includes a child living with natural parents, relatives, or a legal guardian, or the family residence of the child's permanent or temporary foster care or pre-adoption placement. Children receiving Treatment Foster Care Case Management are not eligible for IIH services.

Eligibility Criteria

An Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for IIH services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

Individuals receiving Intensive In-Home (IIH) Services must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual's functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Individuals must demonstrate a clinical necessity for the service arising from a **severe** condition due **to mental, behavioral, or emotional illness** that results in significant functional impairments in major life activities. Individuals must meet **at least two** of the following criteria on a continuing or intermittent basis:

1. Have difficulty due **to mental, behavioral, or emotional illness** in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community; and/or

2. Exhibit such inappropriate behavior due **to mental, behavioral, or emotional illness** that repeated interventions by the mental health, social services, or judicial system are necessary; and/or

3. Exhibit difficulty in cognitive ability due **to mental, behavioral, or emotional illness** such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example, is at risk for acting out in such a fashion that will cause harm to themselves or others.

Services shall be used when there is a risk of out-of-home placement, due to the clinical needs of the child, and either:

1. Services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or

2. The child's residence, as the setting for services, is more likely to be successful than a clinic.

With respect to both 1 and 2, the IIH service specific provider intake must describe how services in the child's residence are more likely to be successful than an outpatient clinic.

"Out-Of-Home" Defined:

An out-of-home placement (at risk of) is defined as one or more of the following:

- Level A or Level B group home
- Regular foster home (if currently residing with biological family and due to behavior problems is at risk of move to DSS custody)
- Treatment foster care placement (if currently residing with biological family or a regular foster family and due to behavior problems is at risk of removal to higher level of care) (IIH services would be provided to the child and the biological family or the foster family)

- Level C residential facility
- Emergency shelter (for child only, due to MH/behavioral problems),
- Psychiatric hospitalization
- Juvenile justice/incarceration placement (detention, corrections)

At-Risk is defined as one or more of the following:

- The youth currently has escalating behaviors that have put them or others at immediate risk of physical injury.
- The parent or legal guardian is unable to manage the mental, behavioral or emotional problems in the home and is actively seeking alternate out of home placement (within the past 2-4 weeks [it needs to be a current problem, not a threat of removal from the home that the parent has made in the past and not acted on]).
- List failed services within the past 30 days from one of the following:
    - Crisis Intervention
    - Crisis Stabilization
    - Outpatient Psychotherapy
    - Outpatient Substance Abuse Services
    - Mental Health Support (recommended age 18 or older)
- Recommendation for IIH by treatment team/FAPT team for a member currently in one of the following:
    - RTC Level C (transition)
    - Group Home Level A or B (transition)
    - Acute Psychiatric Hospitalization (transition)
    - Foster Home (transition, or foster parent is unwilling to continue)
    - MH case management
    - Crisis Intervention
    - Crisis Stabilization
    - Outpatient Psychotherapy
    - Outpatient Substance Abuse Services

The child and at least one parent or responsible adult with whom the child is living must be willing to actively participate and engage in in-home services, with the goal of improving the child's mental health condition in order to keep the child with the family. Services must be directed toward the mental health treatment of the eligible child.

Services may also be used to facilitate mental health treatment after the transition to home from an out-of-home placement when mental health services more intensive than outpatient mental health clinic care are required for the transition to be successful. Upon discharge from Level A, B or C residential care facility, or inpatient psychiatric hospitalization, an Independent Clinical Assessment will not be required if a request is submitted to the BHSA within the 30 calendar days post discharge. An Independent Clinical Assessment will be required should service reauthorization for IIH be medically necessary.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment is allowed within IIH services as long as the treatment for the substance abuse condition is intended to positively impact the child or adolescent's mental health condition. The impact of the child or youth's substance abuse condition on the child or youth's mental health condition must be documented in the ISP and the progress notes.

Required Activities:

- The provider must maintain a copy of the entire fully completed Independent Clinical Assessment in each individual's file. After the Independent Clinical Assessment is completed and prior to admission, a face-to-face service specific provider intake must be conducted and documented. An LMHP or LMHP Supervisee or Resident under the supervision of an LMHP must perform the service specific provider intake to determine all necessary IIH services and determine that the individual's service needs can best be met through interventions provided by this service. If an LMHP Supervisee or Resident performs the service specific provider intake, the service specific provider intake must be reviewed and signed/dated by the LMHP within 24 hours of conducting the service specific provider intake. The service specific provider intake must be conducted face-to-face with the child/youth in the individual's home unless there is a documented safety or privacy issue. If an individual remains in service for more than 12 months, a new intake must be conducted and documented.

- The service specific provider intake must indicate the specifics of how the child meets the service eligibility criteria, is at risk an out of home placement related to their behavioral health issues, and that mental health service needs of the child can best be met through intensive in-home services. The IIH service specific provider assessment must list behavioral health treatments that have been tried or explored within the last 30 days. The service specific provider intake (H0031) must include the items specified by DMAS.

  <u>Service Specific Provider Intake Elements for DMAS Reimbursed Intensive In-Home Service:</u>

  <u>All thirteen elements must be addressed in the service specific provider intake or payment will be retracted.</u>

  1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.

  2. Mental Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses, including the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

3. Medical Profile: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. As needed, an Individualized Fall Risk assessment: Does the individual have any physical conditions or other impairments that put her/him at risk for falling for children 10 years or younger, the risk should be greater than that of other children the same age.

4. Developmental History: Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. Educational/Vocational Status: School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, peer relationships.

6. Current Living Situation and Family History and Relationships: Daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.

7. Legal Status: Indicate individual's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

8. Drug and Alcohol Profile: Substance use / abuse by individual / family members. Type of Substance, Frequency/Duration

9. Resources and Strengths: Document individual's strengths. Extracurricular activities, church, extended family; activities that the individual engages in or are meaningful to the individual.

10. Mental Status Profile

11. Diagnosis: Diagnosis - Includes DSM Code & Description—Diagnosis must be made by an LMHP.

12. Professional Service specific provider intake Summary/ Clinical Formulation: Documentation of needed services. Clinical formulation includes: 1) determining if there are any additional clinical issues that may need to be addressed that were not identified in the VICAP 2) relating the presenting issues identified in the VICAP and during the intake to one another 3) identifying the causes of these presenting issues, and 4) predicting treatment options, outcomes, and barriers to progress, so that an individual specific service plan can be developed.

13. Recommended ISP with time frames..An ISP means a comprehensive and **regularly updated** document specific to the individual being treated containing, but

not necessarily limited to, his treatment or training needs, his goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives and estimated timetable for achieving the goals and objectives. To regularly update the ISP, the provider must provide feedback to the individual and determine incremental progress or lack of progress toward the goals and objectives.

- Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated (more than a year old) intakes/re-assessments and ISPs shall be denied reimbursement.

- An ISP must be fully completed by the QMHP (or LMHP) within 30 days of the initiation of services and must document the need for services. The ISP must demonstrate the need for a minimum of three hours a week of IIH Service.

- If the minimum three hours of service is not provided, there must be documentation of a valid reason. IIH services below the three-hour-per-week minimum may be covered when services are being tapered off prior to discharge. However, variations in the pattern of service delivery must be consistent with the frequency of services specified for the goals and objectives of the ISP. ISPs must incorporate a discharge plan, which identifies transition from intensive in-home to less intensive or non-home-based services. The duration of weeks with fewer than 3 hours of services due to planned discharge may occur within the last 2 weeks of IIH treatment. The ISP plans must be cosigned by the individual and/or parent /guardian participating in treatment.

  If there is a lapse in IIH service for more than two weeks, the reason for the lapse and the rationale for the continued need for the service must be documented. The ISP must be reviewed and updated if there are changes, and signed by either the parent or legal guardian and if appropriate, the individual. This service is designed to address significant needs of an individual at risk of losing their ability to remain in the home environment. Going without services for 2 weeks and no need for a change in the ISP may indicate a lack of need for this level of service. If the lapse is greater than 31 days, a new admission must occur including a new independent clinical assessment, service specific provider intake, and offering of choice of provider.

- Services include: crisis treatment, individual and family counseling, communication skills counseling (to assist the child and parents in practicing appropriate problem-solving, anger management, interpersonal interaction, etc.), case management activities, coordination with other required services, and 24-hour emergency response.

- Services must be delivered in the individual's home with the individual present and the individual and at least one parent or responsible adult with whom the individual is living actively participating in the IIH services. If it is determined that the content of the session is inappropriate for the individual to be present, this must be documented. Documentation must reflect the necessity of providing services related to the individual's behavioral health issues, without the individual present.

- In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community instead of the home, if this is supported by the service specific provider intake and the ISP. IIH services in the community must be as defined in the service definition; this does not include recreation, mentoring, tutoring, or companion-like activities.

- Direct clinical services must be provided by a QMHP-C, QMHP-E, LMHP or a LMHP Supervisee or Resident Provider definitions are provided in Chapter II of this manual under Provider Qualifications.

- An LMHP or a LMHP Supervisee or Resident must provide clinical supervision at regular intervals. The full-time work schedule is 32 hours or more per week. Full time LMHP or the LMHP Supervisee or Resident may supervise up to 10 staff; Half-time staff whose work schedule 16 to 31.9 hours per week may supervise up to five (5) supervisees. If a supervisor works less than half time, the supervision limit is two (2) counselors.

- The LMHP or LMHP Supervisee or Resident must provide clinical supervision weekly, with individual face to face supervision occurring at least every other week. Group supervision may occur on the other weeks. If the supervisor is on leave for one episode that is more than two weeks, a substitute supervisor must provide clinical supervision.

The clinical supervisor (LMHP or LMHP Supervisee or Resident) must be available for consultation as needed, around the clock every day including weekends and holidays.

- Supervision for clinical staff must be documented by the LMHP or LMHP Supervisee or Resident providing the supervision activity. A supervision log or note must be placed in the individual's file documenting that supervision was provided. A more detailed note written by the supervisor summarizing the meeting and noting any recommendations must be maintained in a separate file.

- LMHPs are encouraged to adhere to clinical supervision tenets within their scope of practice and profession's ethical guidelines.

- A QMHP may only provide administrative supervision. The LMHP or LMHP Supervisee or Resident must provide clinical supervision. Administrative supervision is typically geared toward organizational policies and procedures, staff training needs, paperwork, attendance, etc.

- Because Intensive In-Home Services are EPSDT services, a referral should be made to the individual's health care provider for a well child or EPSDT screening.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services, specifically the IIH services.

- If an individual receiving IIH services is also receiving case management services the provider **must** collaborate with the case manager and provide notification of the

provision of services. In addition, the provider **must** send written monthly updates to the case manager on the individual's progress. A discharge summary **must** be sent to the case manager within 30 days of the service discontinuation date.

Limitations

- Intensive In-Home Services (H2012) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider's clinical service specific provider intake will continue to be allowed to be billed without service authorization.

- Due to the intensity level of this service and the significant mental health needs of the eligible individuals, the caseload limit for full time equivalent staff cannot exceed five individuals. If an individual is transitioning out of Intensive In-Home Services, the caseload may be 1:6 for up to 30 days. A team approach may be utilized consistent with FTE ratio above.

- Since case management services are an integral and inseparable part of IIH services, no other type of case management services may be billed separately for periods of time when IIH services are being reimbursed. Coordination **must** occur for all services that the child receives. Only one type of case management can be provided at a time. It is the responsibility of the IIH provider to contact the case management provider to inform them of the receipt of IIH services. Due to the intensity level of this service, it is reasonable to expect that the IIH provider is aware of all other services the individual is receiving.

- Equine therapy is not a reimbursable service.

- Couples therapy that does not directly relate to the individual's behavioral health issues is not reimbursable.

- Tutoring or assisting with academic instruction (for example, homework) is not a reimbursable service.

- Observational sessions greater than one hour conducted in the school environment during the school day will not be reimbursable. These observational sessions must have a specific clinical rationale and be requested by school staff related to the youth's behavioral health problems. Documentation of the request from school staff and details and outcome of the observational session must be documented in the medical record.

- Telephone calls must be limited and may not take the place of Face to Face therapeutic interventions. This service is designed to be provided in the home with the individual and a responsible adult. This service is not appropriate for telemedicine.

- Service is not appropriate for a family while the individual is not living in the home or for families being kept together until an out-of-home placement for the individual can be arranged.

- Staff travel time is excluded.

- Provider transportation is not reimbursable.

- Activities outside the home, such as trips to the library, restaurants, museums, health clubs, shopping centers, and the like, are not considered a part of the scope of services. There must be a clinical rationale documented for any activity provided outside the home. Services may be provided in the community instead of the home if this is supported by the service specific provider intake and the ISP.

- This service may be billed for up to seven days, immediately upon admission to a psychiatric residential treatment facility or immediately prior to discharge from a psychiatric residential treatment facility, to transition the individual from home to the psychiatric residential treatment facility or from the psychiatric residential treatment facility to home, as applicable.

IIH may not be billed prior to discharge from any Level A, Level B, or inpatient hospitalization.

- Outpatient therapy may occur simultaneously as long as services are not duplicated and there is coordination with the treating outpatient therapist by the IIH provider. The service specific provider intake, ISP and progress notes must reflect the need and coordination activities. Coordination should ensure no duplication of services, but also that services are complementary and not providing conflicting interventions for the individual.

  Providers must comply with DBHDS licensing requirements and be licensed to provide intensive in-home services.

Service Units and Maximum Service Limitations

- The service limit for service specific provider intakes is two per provider per individual per fiscal year. A provider may perform this activity twice within a fiscal year per individual, the initial intake and a re-assessment later in the fiscal year. The fiscal year is from July 1 – June 30.

- The service specific provider intake code (H0031) must be billed before the IIH service (H2012) will be paid by the BHSA. For new individuals the service specific provider intake must not occur prior to the Independent Clinical Assessment or there will be post payment retractions (Note Chapter V for service specific provider intake billing instructions).

- The unit of service for IIH service is one hour.

- For reimbursement of this service, a minimum of 3 hours per week of therapeutic intervention must be **medically necessary** for the individual, with a maximum of 10 hours per week. In exceptional circumstances only, and with appropriate supporting documentation that describes medical necessity, providers may bill for up to 15 hours

per week. The BHSA may authorize up to a maximum of 50 hours per calendar month based on medical necessity criteria and the needs of the individual.

The information provided for service authorization must be corroborated and in the provider's clinical record. An approved Service Authorization is required for any units of service (H2012) to be paid. The process for requesting service authorization is detailed in Appendix C of this manual. Providers under contract with the BHSA should contact the BHSA directly for more information.

- A maximum of 26 weeks of Intensive In-Home Services may be authorized annually with coverage under the State Plan Option service. The BHSA stops payment when claims exceed the 26 week service limit allowed in the regulations. If an individual is in need of services beyond the 26 weeks limit, providers must request the service extension through the BHSA under Early and Periodic Screening Diagnosis and Testing (EPSDT). The BHSA starts counting the State Plan Option Service limit on July 1st of every year.
- A week is defined as Sunday through Saturday.
- The annual treatment year for all individuals is defined as the period July 1 through the following June 30.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if the following applies:

   a. The individual is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms; and

   b. The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

   c. The child is no longer in the home.

   d. There is no parent or responsible adult actively participating in the service.

Therapeutic Day Treatment (TDT) for Children and Adolescents (H0035)

Service Definition

Covered services are a combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer

relations, etc) and individual, group, and family psychotherapy offered in programs of two or more hours per day

Eligibility Criteria

Effective July 18, 2011, an Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for TDT services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

Individuals receiving TDT must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual's functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Children and adolescents must demonstrate a clinical necessity for the service arising from a condition due to a **mental, behavioral, or emotional illness** that results in significant functional impairments in major life activities. A psychiatric diagnosis (DSM, Axis I) is required. This determination of significant disability should be based upon consideration of the social functioning of most children who are the same age. The disability must have become more disabling over time (within the past 30 days) and must require **significant** intervention through services that are supportive, intensive, and offered over a period of time in order to provide therapeutic intervention. Individuals must meet **at least two** of the following on a continuing or intermittent basis (within the past 6 months) and the support for this must be clearly documented in the medical record with child-specific examples:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement (see definition below) because of conflicts with family or community.

2. Exhibit such inappropriate behavior that recent repeated interventions by the mental health, social services, educational system, or judicial system are necessary. *For example, crisis intervention services have been provided, outside intervention for truancy have been made, or there have been repeated in school and out of school suspensions that must be addressed as a part of the TDT Individual Service Plan.*

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. *For example the youth exhibits acting out in such a fashion that will cause harm to themselves or others. "*Cognitive" here is referring to the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.

An out-of-home placement (at risk of) is defined as one or more of the following:

- Level A or Level B group home;

- Regular foster home (if currently residing with biological family and due to behavior problems is at risk of move to DSS custody);
- Treatment foster care placement (if currently residing with biological family or a regular foster family and due to behavior problems is at risk of move to higher level of care);
- Level C residential facility;
- Emergency shelter (for child only, due to MH/behavioral problems); or
- Psychiatric hospitalization, juvenile justice/incarceration placement (detention, corrections).

In addition to meeting two of the three criteria listed above, children and adolescents must meet one of the following that must be supported by child-specific documentation in the medical record:

1. Have deficits in social skills, peer relations, or dealing with authority; are hyperactive; have poor impulse control; or are extremely depressed or marginally connected with reality. The deficits or problem behaviors must be documented in the medical record and must be to the level that they significantly impact the individual's abilities to participate in activities of daily living compared to most individuals who are the same age.

2. Would otherwise be placed on homebound instruction because of severe emotional or behavioral problems, or both, that interfere with learning. The medical record must contain documentation from the school that supports this criterion.

3. Require year-round (9-12 months) treatment in order to sustain behavioral or emotional gains. *The medical record must document the need for year-round treatment and any periods when service has been decreased and behavioral or emotional gains have been lost.*

4. Behavioral and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without this programming during the school day or as a supplement to the school day or school year. *The medical record must document the type of classroom programming that is unable to meet the individual's needs, and why the needs are not able to be met and how the problem behaviors are exhibited.*

5. Individuals in preschool enrichment and early intervention programs when the individual's emotional or behavioral problems, or both, are so severe that he/she cannot function in these programs without therapeutic day treatment services. *The medical record must clearly document the severity of the problems and how they impact participation in the preschool or intervention programs.*

If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the

substance abuse condition on the mental health condition must be documented in the ISP and the progress notes.

Required Activities:

- The provider must maintain a copy of the entire fully completed Independent Clinical Assessment in each individual's medical record. Prior to admission, a face-to-face service specific provider intake must be conducted and documented. An LMHP or a LMHP Supervisee or Resident must perform a service specific provider intake to determine all necessary TDT services and eligibility for the service. If an LMHP Supervisee or Resident performs the service specific provider intake, the service specific provider intake must be reviewed with the LMHP within 24 hours of conducting the service specific provider intake. The service specific provider intake (H0032, U7) must include the following elements specified by DMAS. All thirteen elements must be addressed in the service specific provider intake or payment will be retracted.

  1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.

  2. Mental Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses, including the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

  3. Medical Profile: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. As needed, an Individualized Fall Risk assessment: Does the individual have any physical conditions or other impairments that put her/him at risk for falling for children 10 years or younger, the risk should be greater than that of other children the same age.

  4. Developmental History: Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

  5. Educational/Vocational Status: School, grade, special education. IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, peer relationships.

  6. Current Living Situation and Family History and Relationships: Daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the

individual and family's functioning should be listed along with a list of all family or household members.

7. Legal Status: Indicate individual's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

8. Drug and Alcohol Profile: Substance use / abuse by individual / family members. Type of Substance, Frequency/Duration

9. Resources and Strengths: Document individual's strengths. Extracurricular activities, church, extended family; activities that the individual engages in or are meaningful to the individual.

10. Mental Status Profile

11. Diagnosis: Diagnosis - Includes DSM Code & Description—Diagnosis must be made by an LMHP.

12. Professional Service specific provider intake Summary/ Clinical Formulation: Documentation of needed services. Clinical formulation includes: 1) determining if there are any additional clinical issues that may need to be addressed that were not identified in the VICAP 2) relating the presenting issues identified in the VICAP and during the intake to one another 3) identifying the causes of these presenting issues, and 4) predicting treatment options, outcomes, and barrier to progress, so that an individual specific service plan can be developed.

13. Recommended ISP with time frames. An ISP means a comprehensive and **regularly updated** document specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives and estimated timetable for achieving the goals and objectives. To regularly update the ISP, the provider must provide feedback to the individual and determine incremental progress or lack of progress toward the goals and objectives.

- Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated (more than a year old) intakes/re-assessments and ISPs shall be denied reimbursement.

- Service authorization is not required to bill for the face-to-face service specific provider intake. (Note Chapter V for service specific provider intake code and billing instructions).

- The service specific provider intake must be reviewed and updated at least annually by the LMHP or LMHP Resident/Supervisee.

- As needed, referrals to the individual's primary care provider for Early and Periodic, Screening, Diagnosis, and Treatment screening examinations are to be made and documented in the medical record. The results of the screening exams should be included in the medical record.

- Within 30 days of service initiation, a comprehensive ISP indicating all entities participating in treatment must be completed by at least a QMHP-C or QMHP-E documenting the need for services within 30 days of service initiation. Services must be provided in accordance with the ISP. The ISP must be cosigned by the individual or legal guardian. This signature is an indication that the ISP was discussed with the individual or legal guardian.

- Medicaid will only reimburse for allowed service activities. Billing for time spent with the individual but not actively involved in providing services directed by the ISP is not allowed. In addition indirect services (time not spent working with the child or on behalf of the individual) are not allowed to be billed for Medicaid reimbursement.

- Allowed Reimbursable Activities:
    - Completing diagnostic evaluations, identifying treatment needs;
    - Consultation with teachers and others involved in the individual's treatment and observation in the classroom.
    - Planning and implementing individualized pro-social skills curriculums and interventions; e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.),
    - Monitoring progress in demonstrating the acquisition of pro-social skills (anger management, problem-solving skills, identification and appropriate verbalization of feelings, conflict resolution, etc.); (monitoring includes providing feedback to the individual on the acquisition of these skills);
    - Implementing cognitive-behavioral programming;
    - Planning and implementing individualized behavior modification programs and monitoring progress through collaboration with school personnel, family, and others involved in the individual's treatment; (Family contacts, either in person or by telephone, occurs at least once per week.
    - Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day; services should include a "de-briefing" with the individual and family to discuss the incident; how to recognize triggers, identify alternative coping mechanisms and providing feedback on the use of those alternative coping mechanisms.
    - Providing individual, group, and family counseling based on specific TDT objectives identified in the ISP;
    - Collaborating with all other community practitioners providing services to the individual, including scheduling appointments and meetings, and
    - If the individual is on medication related to their behavioral health needs, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the individual and parent/ guardian and documented. Response to medication and education, as well as compliance must also be documented.

- Activities that are not allowed / reimbursed:
    - Inactive time or time spent waiting to respond to a behavioral situation;

  - Transportation; and
  - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services and TDT specifically.

- A daily log of services provided is documented. Documentation of the individual's response to the interventions must be included in the daily log. A minimum of a weekly summary must include a description of the individual's behavior, the staff interventions, and the response to the interventions. The summary must support the time billed and must be filed in the medical record within 1 week of service provision. The weekly summary must include a description of all intensive behavioral health provided to support the number of units billed for the specific date of service.

- If there is a lapse in service for more than two weeks, the reason for the lapse and the rationale for the continued need for the service must be documented. The ISP must be reviewed, updated to determine if there are changes, and signed by either the parent or legal guardian and if appropriate, the individual. If the lapse is greater than 31 calendar days, a new admission must occur including a new independent clinical assessment, service specific provider intake, and offering of choice of provider.

Limitations

- The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., before school, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group counseling/therapy and psycho-educational activities.

- At a minimum, services are provided by a QMHP-C or QMHP eligible staff.

- The caseload for the direct service provider is a maximum of six (6) children per day.

- Therapeutic group activities, such as counseling, psychotherapy, and psycho-education are limited to no more than 10 individuals.

- If an individual receiving Therapeutic Day Treatment for Children and Adolescents is also receiving case management services the provider must collaborate with the case manager and pediatrician by notifying the case manager and the pediatrician of the provision of Therapeutic Day Treatment for Children and Adolescents. Written monthly updates on the individual's progress are to be sent to the case manager. A written discharge summary must be sent to the case manager within 30 days of when the service is discontinued.

- Services must not duplicate those services provided by the school.

- Staff travel time is excluded.

- Therapeutic Day Treatment Services (H0035) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider's service specific provider intake will continue to be allowed to be billed without service authorization.

Service Units and Maximum Service Limitations

- There is a maximum of 780 units that are allowed based on medical necessity per fiscal year.

  One unit = 2 to 2.99 hours
  Two units = 3 to 4.99 hours
  Three units = 5 plus hours
  No more than three units maybe billed per day.

Claims must be billed with an HA modifier. (Please note the special billing instructions included in Chapter V of this manual). Providers under contract with the BHSA should contact the BHSA directly for more information.

- A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement. Providers under contract with the BHSA should contact the BHSA directly for more information..

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if the following applies:

   a. The individual does not demonstrate meeting the eligibility criteria and;

   b. The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

<u>Community-Based Residential Services for Children and Adolescents under 21 (Level A)</u> - H2022 HW (CSA), H2022 HK (non CSA)

Service Definition

Community-Based Residential Services for Children and Adolescents under 21 (Level A Group Homes) are a combination of therapeutic services rendered in a residential setting.

This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and behavioral health treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan. The individual must also receive at least weekly individual psychotherapy services (provided by an LMHP or LMHP Resident/Supervisee) in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the individual. Service authorization is required for Medicaid reimbursement.

Eligibility Criteria

Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral, or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the individual's condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when all of the following (A-F) are met:

A) The individual is medically stable, but needs intervention to comply with mental health treatment; and

B) The individual's mental health needs cannot be met with a less intense service; and

C) An intake demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment tool (CANS) must be completed by the locality for Comprehensive Services Act (CSA) individuals and must be current to within 30 days prior to placement. For non-CSA individuals, a service specific provider intake must be completed by the independent referring clinician noting at least two moderate impairments within the past 30 days. A moderate impairment is evidenced by, but not limited to:

(1) Frequent conflict in the family setting such as credible threats of physical harm. Frequent is defined as more than expected for the child's age and developmental level.

(2) Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

(3) Severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

(4) Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

D) Limited ability to consider the effect of one's inappropriate conduct on others and interactions consistently involving conflict, which may include impulsive or abusive behaviors. ; For non CSA children the service specific provider intake must be completed by the independent referring clinician prior to admission. The service specific provider intake must contain all of the following elements:

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.

2. Mental Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses, including the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

3. Medical Profile: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. As needed, an Individualized Fall Risk assessment: Does the individual have any physical conditions or other impairments that put her/him at risk for falling for children 10 years or younger, the risk should be greater than that of other children the same age.

4. Developmental History: Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. Educational/Vocational Status: School, grade, special education. /IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, peer relationships.

6. Current Living Situation and Family History and Relationships: Daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.

7. Legal Status: Indicate individual's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

8. Drug and Alcohol Profile: Substance use / abuse by individual / family members. Type of Substance, Frequency/Duration

9. Resources and Strengths: Document individual's strengths. Extracurricular activities, church, extended family; activities that the individual engages in or are meaningful to the individual.

10. Mental Status Profile

11. Diagnosis: Diagnosis - Includes DSM Code & Description—Diagnosis must be made by an LMHP.

12. Professional Service specific provider intake Summary/ Clinical Formulation: Documentation of needed services. Clinical formulation includes: 1) determining if clinical issues that need to be addressed that were not identified in the CON 2) relating the presenting issues identified in the CON and during the intake to one another 3) identifying the causes of these presenting issues, and 4) predicting treatment options, outcomes, and barrier to progress, so that an individual specific service plan can be developed.

13. Recommended ISP with time frames. An ISP means a comprehensive and **regularly updated** document specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives and estimated timetable for achieving the goals and objectives. To regularly update the ISP, the provider must provide feedback to the individual and determine incremental progress or lack of progress toward the goals and objectives.

- Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated (more than a year old) intakes/re-assessments and ISPs shall be denied reimbursement.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

E) Independent Team Certification The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission.**; and**

For CSA individuals, the Family Assessment and Planning Team's (FAPT) identification of the need for the service and the Community Policy and

Management Team's (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the individual's primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA individuals only, the placing agent must give the provider the name of the locality fiscally responsible for the individual. The provider will submit this information to the BHSA.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent's PCP and an LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.

A Medicaid-reimbursed admission to a Level A Group Home may only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual; and

2. Proper treatment of the child's psychiatric condition requires services in a community-based residential program.

3. The services may reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the LMHP and the physician prior to the start of services (see "Exhibits" section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that:

1) Includes a licensed physician who:

(i) Has competence in diagnosis and treatment of pediatric mental illness; and
(ii) Has knowledge of the individual's mental health history and current situation.

B. For an individual who applies for Medicaid while an inpatient in the facility or program, the certification must:

1) Be made by the team responsible for the CIPOC;

2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

3) Includes the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

The Initial Plan of Care (IPOC) must be completed upon admission at least by a QMHP and must be signed and dated by the program director. (See the "Exhibits" section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The IPOC must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the child;

3. Treatment objectives with short-term and long-term goals;

4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and;

6. Plans for discharge.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

Continued Stay Criteria for Level A

Service authorization through Magellan for continued stay is required. A qualified mental health provider (QMHP) must re-assess the medical necessity for service after six consecutive months and prior to the initial service authorization expiration. The re-assessment must also be signed by a licensed mental health provider (LMHP). The LMHP for the re-assessment and continued service authorization may be an independent

practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that assesses and recommends continuation of the service must also be in the individual's record.

1. For continued treatment beyond the initial six month authorization, the current (within 30 days) Comprehensive Individual Plan of Care (CIPOC) update of progress related to the goals and objectives must document the need for the continuation of the service.

2. For re-authorization to occur, either the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the individual's CIPOC or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains, and use of less intensive services will not achieve stabilization. InterQual Criteria must be met as well as any one of the following must apply:

   A) The individual has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.

   B) The individual is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.

   C) The individual is not making progress, and the CIPOC has been modified to identify more effective interventions.

   D) There are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

Required Activities:

- A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the QMHP within 30 days of authorization for Medicaid reimbursement. The CIPOC must be re-written annually. (See the "Exhibits" section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

  The CIPOC must:

  1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for residential psychiatric care;

  2. Be based on input from school, home, other healthcare providers, the individual, and family (or legal guardian);

  3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;

5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual's family, school, and community;

6. The CIPOC must be reviewed and signed by a QMHP every 30 days. The review must include:
   - The response to services provided; and
   - Recommended changes in the plan as indicated by the individual's overall response to the ISP interventions; and
   - Determinations regarding whether the services being provided continue to be required; and
   - Updates must include the dated signatures of the QMHP service provider.

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues indicated in the individual's IPOC and the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. Psycho-education refers to education on mental health topics to improve the individual's behavioral, mental, or emotional condition. The child must participate in seven (7) psycho-educational activities per week. Program activities must be documented at the time the service is rendered and must include the dated signatures of qualified staff rendering the service.

- In addition to the residential services, the child must receive at least weekly, individual psychotherapy that is provided by an LMHP. Family psychotherapy may also to be provided if there is continued family involvement. Therapy sessions are limited to no more than three (3) sessions in a seven-day period, including individual, family and group psychotherapy. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized (see the *Psychiatric Services* Provider Manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and documentation criteria.) If the weekly psychotherapy is missed due to the individual's illness or refusal, justification must be documented in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up a missed session.

- The facility/group home must coordinate services with other providers.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of this community mental health rehabilitative service.

- If an individual receiving Community-Based Services for Children and Adolescents under 21 (Level A) is also receiving case management services the provider must collaborate with the case manager by notifying the case manager of the provision of Level A services and send written monthly updates on the individual's progress. A written discharge summary must be sent when the service is discontinued.

- The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while the children/adolescents are scheduled to be asleep. To assist in assuring client safety, the agency must provide adequate supervision of residents at all times, including off campus activities.

- The program director supervising the program/group home must be, at a minimum, a qualified mental health professional and employed full time.

- At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.

- Services may be rendered by an LMHP, LMHP Supervisee or Resident, QMHP-C, QMHP-E and QPPMH.

Therapeutic Passes

Therapeutic passes are permitted if the goals of the pass are part of the CIPOC. The goals of a particular visit must be documented prior to granting the pass. When the individual returns from the pass, the response to the pass must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the pass is to assess the individual's ability to function outside the structured environment and to function appropriately within the family and community.

A. Overnight therapeutic passes may occur only after the completion and documentation of successful day therapeutic passes and as a part of the discharge plan. Outcomes of the therapeutic passes must be documented. No more than 24 days of therapeutic passes annually are allowed. Therapeutic pass time is counted from the date of admission to Medicaid covered services at the A and B levels. If an individual has successfully completed therapeutic day passes at a higher level of care in the previous placement the child/adolescent may be granted overnight therapeutic passes prior to the completion of day therapeutic passes at the new program if clinically indicated. Provision of active therapeutic services while on overnight therapeutic passes is required to bill for days away from the facility.

B. If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

- None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a BHSA residential service authorization.

Limitations

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

DMAS does not pay for programs/facilities that only provide independent living services.

Service Units and Maximum Service Limitations

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included.

Service authorization is required for payment of all residential services billed to the BHSA. Please note that the service authorization process is described in Appendix C of this manual. Providers under contract with the BHSA should contact the BHSA directly for more information.

The fiscal years will be run from July 1 through June 30.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization. Reimbursement shall not be made for this level of care if any of the following applies:

a. The level of functioning has improved with respect to the goals outlined in the CIPOC and the individual can reasonably be expected to maintain these gains at a lower level of treatment; or

b. The individual no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 days.

c. InterQual® Behavioral Health criteria and Community Based Treatment criteria is no longer met.

Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) **H2020 HK** (non-CSA)

Service Definition

Therapeutic Behavioral Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the ISP. The individual must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or the academic educational needs of the members. Service authorization is required for Medicaid reimbursement. See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Eligibility Criteria

Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral, or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the individual's condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when all of the following (A-F) are met:

A. The individual is medically stable, but needs intervention to comply with mental health treatment; AND

B. The individual's needs cannot be met with a less intense service; AND

C. An assessment demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment (CANS) tool must be completed by the locality for Comprehensive Services Act (CSA) children/adolescents and must be current to within 30 days prior to placement. For non-CSA children, a service specific provider intake and a CANS must be made by the EPSDT physician and an independent LMHP noting at least two moderate impairments within the past 30 days. A moderate impairment is evidenced by, but not limited to:

1. Frequent conflict in the family setting; for example, credible threats of physical harm. Frequent is defined as more than expected for the child's age and developmental level.

2. Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

3. Severely limited involvement in social support; which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

4. Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

5. Limited ability to consider the effect of one's inappropriate conduct on others and/or interactions consistently involving conflict, which may include impulsive or abusive behaviors.

D. For non-CSA children a service-specific provider intake must be completed by an LMHP or LMHP Supervisee or Resident prior to admission. If the service-specific provider intake is completed by an LMHP Supervisee or Resident it must be reviewed, signed and dated within 24 hours by an LMHP in order to receive Medicaid Reimbursement. The service-specific provider intake must contain all of the following elements.;

1) **Presenting Issue(s)/Reason for Referral:** Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms during the 30 days immediately prior to admission. Identify precipitating events/stressors, relevant history. If the child is at risk of an out of home placement, state the specific reason.

2) **Mental Health History/Hospitalizations:** Give details of mental health history and any mental health related hospitalizations and diagnoses, including list the types of interventions that have been provided to the member. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past and outcomes of each placement.

3) **Medical Profile:** Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. Individualized Fall Risk assessment**:** Does client have any physical conditions or other impairments that put her/him at risk for falling For children 10 years or younger, the risk should be greater than that of other children t he same age.

4) **Developmental History:** Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5) **Educational/Vocational Status:** School, grade, special ed./IEP status, grades, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships.

6) Current **Living Situation and Family History and Relationships:** Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning should be listed as well as a list of all family members and level of family support available.

7**) Legal Status:** Indicate client's criminal justice status. This includes pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations.

8) **Drug and Alcohol Profile:** Substance use / abuse of client / family members. Type of Substance, Frequency/Duration

9**) Resources and Strengths:** Verbalize member's strengths. Extracurricular activities, church, extended family

10) **Mental Status Profile.**

11) **Diagnosis:** Diagnosis - Includes DSM Code & Description.

12) P**rofessional Service specific provider assessment Summary/ Clinical Formulation**: Documentation of the needed services. Clinical formulation includes: 1) determining if clinical issues that need to be addressed that were not identified in the CANS 2) relating the presenting issues identified in the CANS and during the intake to one another 3) identifying the causes of these presenting issues, and 4) predicting treatment options, outcomes, and barrier to progress, so that an individual specific service plan can be developed.

13) Recommended ISP with time frames. An ISP means a comprehensive and **regularly updated** document specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives and estimated timetable for achieving the goals and objectives. To regularly update the ISP, the provider must provide feedback to the individual and determine incremental progress or lack of progress toward the goals and objectives.

E. Independent Team Certification - The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission; **and**

For CSA children, the Family Assessment and Planning Team's (FAPT) identification of the need for the service and the Community Policy and Management Team's (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the child or adolescent's primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA children only, the placing agent must give the provider the name of the locality fiscally responsible for the child. The provider will be submitting this information to the service authorization contractor.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent's PCP and a LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.

A Medicaid-reimbursed admission to a community residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual;

2. Proper treatment of the individual's psychiatric condition requires services on in a community-based residential program; and

3. The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the screener and the physician prior to the start of services (see "Exhibits" section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that:

1) Includes a licensed physician who:

   (i) Has competence in diagnosis and treatment of pediatric mental illness; and
   (ii) Has knowledge of the individual's mental health history and current situation.

B. For an individual who applies for Medicaid while an inpatient in the facility or program, the certification must:

1) Be made by the team responsible for the CIPOC;
2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and
3) Includes the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

The Initial Plan of Care (IPOC) must be completed upon admission by the QMHP and must be signed and dated by the program director. (See the "Exhibits" section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The IPOC must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the child;

3. Treatment objectives with short-term and long-term goals;

4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and;

6. Plans for discharge.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

Continued Stay Criteria for Level B

Service authorization through Magellan for continued stay is required. A qualified mental health provider (QMHP) must re-assess for medical necessity for service after consecutive six months. The re-assessment must also be signed by a licensed mental health provider (LMHP). The LMHP for the re-assessment and continued service authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that assesses and recommends continuation of the service must also be in the individual's record.

1. For continued treatment beyond the initial six month authorization a current CIPOC and a current (within 30 days) progress update related to the goals and objectives on the CIPOC must document the need for the continuation of the service.

2. For authorization to occur past the initial six months, either the desired outcome or level of functioning has not been restored or improved in the time frame outlined in the individual's ISP, or the individual continues to be at risk for relapse based on recent history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. InterQual® criteria must be met as well as any one of the following:

   A. The individual has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.

   B. The individual is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.

   C. The individual is not making progress, and the CIPOC has been modified to identify more effective interventions.

   D. There are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic passes or stays in a non-treatment residential setting or in a lower level of care.

- A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the LMHP within 30 calendar days of admission;

  The CIPOC must:

  1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;

  2. Be based on input from school, home, other healthcare providers, the individual, and family (or legal guardian);

  3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

  4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;

  5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual's family, school, and community; and

  6. The CIPOC must be reviewed signed by the LMHP every 30 calendar days. The review must include:

     - The response to services provided;

- Recommended changes in the plan as indicated by the individual's overall response to the CIPOC interventions;
- Determinations regarding whether the services being provided continue to be required; and
- Updates must be signed and dated by the LMHP service provider.

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues. indicated in the individual's IPOC and the CIPOC.

- Daily documentation of services provided must clearly reflect behaviors, activities, and treatment methodologies that indicate attention to and movement toward stated goals and objectives in the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. Psycho-education refers to education on mental health topics to improve the individual's behavioral, mental, or emotional condition. The individual must participate in seven (7) psycho-educational activities per week. Program sessions must be documented at the time the service is rendered and must be signed and dated by the qualified staff rendering the service.

- In addition to the residential services, the individual must receive at least weekly, individual psychotherapy that is provided by a LMHP. Family psychotherapy may also to be provided if there is continued family involvement. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized in addition to the authorization for the residential services. (See *Psychiatric Services* provider manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and criteria) If the weekly psychotherapy is missed due to the individual's illness or refusal written justification must be in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up missed sessions.

- Individuals receiving Therapeutic Behavioral Services (Level B) must also receive group psychotherapy that is provided as part of the program. If provided by a Medicaid-enrolled LMHP, group psychotherapy may be billed separately and must be prior authorized in addition to the authorization for the residential services (See *Psychiatric Services* provider manual, Chapter IV and Appendix C, for details on outpatient requirements and pre-authorization procedures).

- The facility/group home must coordinate services with other providers.

- <u>The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of this community mental health rehabilitative service.</u>

- If an individual receiving Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is also receiving case management services the

provider must collaborate with the case manager by notifying the case manager of the provision of Level B services and send written monthly updates on the individual's progress. A written discharge summary must be sent when the service is discontinued.

- The staff ratio must be at least 1 staff to 4 children during the day and at least 1 staff to 8 children while the children/adolescents are scheduled to be asleep. To assist in assuring client safety, the agency must provide adequate supervision of individuals at all times, including off campus activities.

- In order for Medicaid reimbursement to be approved, at least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.

- These services may be rendered by an LMHP, LMHP Supervisee or Resident, QMHP-C, QMHP-E, and QPPMH.

Therapeutic Passes

Therapeutic passes are permitted if the goals of the therapeutic pass are part of the CIPOC. The goals of a particular therapeutic pass must be documented prior to granting the pass. When the individual returns from the therapeutic pass, the response to the pass must be documented. Therapeutic passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the therapeutic pass is to assess the individual's ability to function outside the structured environment and to function appropriately within the family and community.

A. Overnight therapeutic passes may occur only after the completion and documentation of successful day therapeutic passes and as a part of the discharge plan. Outcomes of the therapeutic pass must be documented. Therapeutic passes may not exceed more than 24 days annually. Therapeutic pass time is counted from the date of admission to Medicaid covered services at the A and B levels. If an individual has successfully completed therapeutic day passes at a higher level of care in the most recent previous placement the individual may be considered for overnight therapeutic passes prior to the completion of day therapeutic passes at the new program if clinically indicated. Provision of active therapeutic services by the Level B provider while on overnight therapeutic passes is required to bill for days away from the facility.

B. If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 consecutive days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

C. None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a /BHSA residential service authorization.

Limitations

The BHSA will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

Programs/facilities that only provide independent living services are not reimbursed.

The caseload of the clinical director must not exceed a total of 16 clients including all sites for which the clinical director is responsible.

Service Units and Maximum Service Limitations

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the individual. Room and board costs are not included in the rate. Service authorization is required for payment of all residential services. The service authorization process is described in Appendix C of this manual. Providers under contract with the BHSA should contact the BHSA directly for more information.

The fiscal years will be run from July 1 through June 30.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if any of the following applies:

    a. The level of functioning has improved with respect to the goals outlined in the ISP, and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

    b. The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.

    c. InterQual® Behavioral Health Criteria, and Residential and Community-Based Treatment criteria is no longer met.

Day Treatment/Partial Hospitalization (H0035 HB)

Service Definition

Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition.

The services are delivered when the individual is at risk of inpatient psychiatric hospitalization or is transitioning from an inpatient psychiatric hospitalization to the community. Day Treatment/Partial Hospitalization services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting.

Eligibility Criteria

In order to receive Medicaid-reimbursed Day Treatment/Partial Hospitalization Services, individuals must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet **at least two** of the following on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric inpatient hospitalization or homelessness or isolation from social supports;

2. Experience difficulty in activities of daily living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

3. Exhibit behavior that requires repeated interventions or monitoring by the mental health, social services, or judicial system are necessary; or

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. "Cognitive" here is referring to the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Day Treatment/Partial Hospitalization as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider intake, the ISP, and the progress notes.

Required Activities

- Major diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment but do not require psychiatric inpatient treatment. Psycho-education refers to education on mental health topics to improve the individual's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or licensed clinical nurse specialist-psychiatric must perform a face-to-face evaluation/diagnostic service specific provider intake prior to initiation of treatment. Service authorization is not required to bill for the face-to-face service specific provider intake. (Note Chapter V for service specific provider intake code and billing instructions).

- An ISP must be completed by a QMHP or an LMHP within 30 days of service initiation. The ISP must be cosigned by the individual.

- Services must be provided in accordance with the ISP.

- Progress notes for Day Treatment/Partial Hospitalization Services are completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the arrival and departure time of each individual to and from the program, the amount of service delivered, and a staff's signature and credentials, and a date.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP-A or LMHP or LMHP Resident/Supervisee, by a QMHP-A, QMHP-E, LMHP, or LMHP Supervisee or Resident.

- Supervision by the QMHP-A, LMHP or LMHP Supervisee or Resident is demonstrated by a review of progress notes, the individual's progress toward achieving ISP goals and objectives and recommendations for change based on the individual's status. Supervision must occur monthly. Documentation that supervision occurred must be in the individual's clinical record and signed by the QMHP-A, LMHP or LMHP Supervisee/Resident. Individual, group, or a combination of individual and group supervision is acceptable.

- LMHPs are encouraged to adhere to clinical supervision tenets within their scope of practice and profession's ethical guidelines.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP-A. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and

recommendations for ISP change based on the individual's status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two continuous hours in a 24-hour period.
- A physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist must perform a face-to-face evaluation for services that are provided longer than 90 calendar days. This evaluation must be completed no later than 90 calendar days from the start of services.
- If case management is being provided, there must be coordination with the case management agency.
- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services, specifically this service.

Limitations

- Day Treatment/Partial Hospitalization Services (H0035) requires service authorization (and re-authorization) before any services (beyond the service specific provider intake) are reimbursed. The provider's clinical service specific provider intake will continue to be allowed to be billed without service authorization.
- Staff travel time is excluded.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization. Reimbursement shall not be made for this level of care if the following applies:

a. The individual is no longer in an acute psychiatric state and at risk of psychiatric hospitalization and;

b. The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

Service Units and Maximum Service Limitations

- One unit= 2-3.99 hours/day
- Two units= 4-6.99 hours/day
- Three units= 7+ hours/day

A maximum of 780 units of Partial Hospital / Day Treatment is allowable annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement. Providers under contract with the BHSA should contact the BHSA directly for more information.

Psychosocial Rehabilitation (H2017)

Service Definition

Psychosocial rehabilitation services are programs of two or more consecutive hours per day provided to groups of individuals in a non-residential setting. Services include assessment, education to teach the individual about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

Eligibility

Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the community or (ii) who meet at least two of the following on a continuing or intermittent basis:

1. Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

2. Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

3. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; or

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. "Cognitive" here is referring to the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.

To receive Psychosocial Rehabilitative services, the individual must meet one of the criteria listed below. The individual must:

1. Have experienced long-term or repeated psychiatric hospitalizations; or
2. Lack daily living skills and interpersonal skills; or
3. Have a limited or non-existent support system; or
4. Be unable to function in the community without intensive intervention; or
5. Require long-term services to be maintained in the community.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Psychosocial rehabilitation services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Required Activities:

Prior to treatment, there must be a face-to-face service specific provider intake by an LMHP, LMHP Supervisee or Resident, QMHP-A or QMHP-E. If the service specific provider assessment is done by a QMHP-A or QMHP-E, it must be approved by an LMHP or an LMHP Supervisee or Resident within 30 days of admission to service. Service authorization is not required to bill for the face-to-face service specific provider intake. (Note Chapter V for the service specific provider intake code and billing instructions). Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

- Within 30 calendar days of service initiation, the ISP must be completed by the LMHP, LMHP Supervisee or Resident, or a QMHP-A or QMHP-E and must clearly document the need for the services. The ISP must be cosigned by the individual receiving services.
- Every three months, the LMHP, LMHP Supervisee or Resident, or the QMHP A or QMHP-E must review, modify as appropriate, and update the ISP with the individual.
- Services that continue for more than six months must be reviewed by an LMHP or LMHP Supervisee or Resident. The LMHP or LMHP Supervisee or Resident must document the need for continued services. The ISP must be rewritten at least annually.
- Perform education to teach the individual about mental illness and appropriate medication to avoid complications and relapse, provide opportunities to learn and use independent living skills, and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

- Services must be provided in accordance with the ISP.

- Progress notes for psychosocial rehabilitation services are completed at least monthly. Notes must specifically describe the specific service that was provided. Notes must correlate with time billed.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP-A, QMHP-E, LMHP, or an LMHP Resident/Supervisee.

- Supervision is demonstrated by a review of the individual's progress towards achieving ISP goals and objectives and recommendations for ISP change based on the individual's status. Supervision (this may be a group supervisory meeting with all paraprofessionals and a discussion of multiple individuals) must occur and be documented in the clinical record monthly.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional (this may be a group supervisory meeting with all paraprofessionals and a discussion of multiple individuals), and a review of the individual's progress towards achieving ISP goals, and objectives and recommendations for ISP change based on the individual's status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two continuous hours in a 24-hour period.

- If case management is being provided, there must be coordination with the case management agency.

- The service provider must notify the primary care provider of the individual's receipt of community mental health rehabilitative services, specifically psychosocial rehabilitation services.

Service Units and Maximum Service Limitations

- One unit = 2 to 3.99 hours per day
- Two units = 4 to 6.99 hours per day
- Three units = 7 + hours per day.

- Time for field trips (off-site activities) is allowed if the goal of the trip is to provide an opportunity for supervised practice of socialization skills or therapeutic activities that are designed to increase the individual's understanding or ability to access community services and this is an identified need in the intake and ISP.

- Staff travel time is excluded.

- Vocational services are not reimbursable.
- A maximum of 936 units of Psychosocial Rehabilitation is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.
- Psychosocial Rehabilitation Services (H2017) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider's clinical service specific provider intake will continue to be allowed to be billed without service authorization.
- The service authorization process is described in Appendix C of this manual. Providers under contract with the BHSA should contact the BHSA directly for more information.

Crisis Intervention (H0036)

Service Definition

Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute psychiatric dysfunction requiring immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the member or others; and
- To provide treatment in the least restrictive setting.

Crisis intervention activities shall include assessing the crisis situation, providing short-term Counseling to stabilize the individual or family unit, providing access to further immediate service specific provider intake and follow-up; and link the individual and family with ongoing care to prevent future crises.

Eligibility

Crisis intervention services are provided following a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. After the initial contact, to provide further crisis counseling, individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are necessary; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Crisis Intervention Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider intake, the treatment plan, (please see below for ISP requirements), and the progress notes.

Required Activities

- An LMHP, LMHP Supervisee or Resident, Certified Pre-screener or QMHP must complete and document a face-to-face service specific provider intake of the crisis situation. If the service specific provider intake is performed by the QMHP, it must be reviewed and approved by an LMHP, LMHP Supervisee or Resident, or Certified Pre-screener within 72 hours.

- The service-specific provider intake must document the need for and the anticipated duration of the crisis service.

- Services may be provided to eligible individuals outside of the clinic and billed if it is clinically or programmatically appropriate, or both.

- There must be documentation of an immediate mental health service need with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.

- Services must be documented through daily notes and a daily log of time spent in the delivery of services.

- Services may include office visits, home visits, pre-admission screenings, telephone contacts, or other client-related activities for the prevention of institutionalization. Note: Pre-admission screenings must be done by the CSB/BHA or, for children and adolescents under 21, by an independent team.

Both the team and the independent team must meet federal regulations for an independent team.

NOTE: Medicaid cannot be billed for crisis intervention services for an individual under Emergency Custody Orders (ECOs) or Temporary Detention Orders (TDOs). Services may be billed up to the time an order for TDO or ECO is received. If the ECO ends without a TDO being called, services rendered after the ECO ends may be reimbursed. Documentation of TDOs and ECOs must clearly delineate the separation of time. Refer to the *Hospital* Provider Manual, Appendix B, for further information.

- Face-to-face contact with the individual must occur during the crisis episode in order to bill Medicaid for Crisis Intervention Services. Other contacts, such as telephone calls and collateral contacts during the crisis episode are reimbursable as long as the requirement for a face-to-face contact is met. Billable contacts which are directed toward crisis resolution for the member may occur prior to the face-to-face contact.

- Crisis intervention services may involve the individual's family or significant others.

- An ISP is not required for newly admitted individuals unless they are receiving scheduled, short-term counseling as part of the crisis intervention service. Inclusion of the service on the existing ISP is not required for the service to be provided to an active member on an emergency basis.

- For individuals who receive scheduled, short-term counseling as part of the crisis intervention service, an ISP prepared by at least a QMHP-E must be developed or revised to reflect treatment goals and interventions by the fourth face-to-face contact. The ISP must be cosigned by the individual receiving services. See above for medical necessity criteria for short-term counseling.

- Services are provided by an LMHP, LMHP Supervisee or Resident, a Certified Pre-screener ***or*** a QMHP-A, QMHP-C, or QMHP-E.

- If case management is being provided, there must be coordination with the case management agency.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member's receipt of this community mental health rehabilitative services.

Limitations

- Staff travel time is excluded from billable time.

- If other clinic services are billed while the individual is receiving Crisis Intervention services, documentation must clearly support the separation of the services with distinct treatment goals. Only one service may be billed during the same moment in time.

Service Units and Maximum Service Limitations

- A unit of service is 15 minutes of Crisis Intervention. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed.

- A maximum of 720 units of Crisis Intervention may be provided annually. Each July 1st, all service limits will be set to zero. The fiscal year is July 1 through June 30.

- Reimbursement will be provided for short-term crisis counseling contacts scheduled within 30 calendar days from the time of the first face-to-face crisis contact.

- While service authorization for this service is not required, registration of this service with the BHSA is required effective April 1, 2014. Providers under contract with the BHSA should contact the BHSA directly for more information.

Intensive Community Treatment (H0039)

Service Definition

Intensive Community Treatment (ICT) is an array of mental health services for individuals with significant mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. ICT has been designed to be provided through a designated multi-disciplinary team of mental health professionals. It is available either directly or on call 24 hours per day, seven days per week, 365 days per year.

Eligibility Criteria

The individual is best served in the community. The individual also must meet at least one of the following criteria:

1. Is at high risk for psychiatric hospitalization or for becoming or remaining homeless due to mental illness, or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.

2. Has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance abuse and demonstrates a resistance to seek out and utilize appropriate treatment options.

If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within ICT as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be

documented in the service specific provider assessment, the ISP, and the progress notes.

Required Activities

Medical psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting will be provided to individuals who are best served in the community.

- A service-specific provider intake which documents eligibility and the need for this service must be completed by the LMHP, LMHP Supervisee or Resident or the QMHP-A or QMHP-E prior to the initiation of services. A LMHP reviews the service specific provider assessment within 30 day and certifies that the individual is in need of the services. Service authorization is not required to bill for the face-to-face service specific provider intake. (Note Chapter V for the service specific provider assessment code and billing instructions).

- An ISP, based on the needs outlined in the service-specific provider intake must be initiated at the time of admission and fully developed by at least the QMHP-E and approved by the LMHP or LMHP Supervisee or Resident within 30 calendar days of service initiation; The ISP should be cosigned by the individual.

- Services are provided in accordance with the ISP;

- Services may be provided by a QMHP-E or a paraprofessional who is under the supervision of at QMHP or LMHP;

- Documentation is created and maintained through a daily service log of time spent in the delivery of services and a description of the activities and services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives outlined in the ISP; and

- Coordination to ensure there is no duplication in services or billing and to ensure continuity of care.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of this community mental health rehabilitative services.

Limitations

- No billing is allowed during the same time period for any outpatient psychotherapy services or case management. Crisis stabilization may be billed if:

    1. Services are provided in a community-based residential setting; and
    2. Services meet the criteria for crisis stabilization services; and
    3. ICT is not billed for the days that crisis stabilization is billed.

- ICT services may be billed if the individual is brought to the clinic by ICT staff to see the psychiatrist. Documentation to support this intervention must be in the individual's clinical record.

- As part of ICT, psychotherapy and medication management are generally expected to be provided outside the clinic, hospital, or office setting. In preparation for transition to a lesser level of care, if an ICT member goes to the clinic independently (as part of the plan of care for transitioning to less intensive services) psychotherapy and medication management services may be billed as ICT services. The ICT plan of care must continue to document the need for the intense level of services provided in ICT. (If the individual regularly attends office based medical appointments that are no more than twenty five percent of billed ICT time, the need for continuance of ICT services based on resistance and/or inability to benefit from a lesser level of intensity than ICT shall be documented in the clinical record). Time billed for psychotherapy, medication management, and other clinic services may not exceed twenty-five percent of the total time billed for ICT during this transition period. The transition period is limited to a maximum of eight (8) weeks.

Service Units

- ICT may be provided based on an initial service specific provider intake. This service may be provided for a maximum of 26 weeks with a limit of 130 units available annually. Continuation of service may be reauthorized at 26-week intervals based on written service specific provider re-assessment and certification of need by a LMHP.

- A maximum of 130 units of Intensive Community Treatment may be authorized annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

- Intensive Community Treatment (H0039) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider's clinical service specific provider intake will continue to be allowed to be billed without service authorization.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement. Providers under contract with the BHSA should contact the BHSA for more information.

Crisis Stabilization (H2019)

Service Definition

Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and

security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Eligibility Criteria

To qualify for this service, individuals must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet **at least two** of the following criteria at the time of admission to the service:

1. Experiencing difficulty in establishing and maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization or homelessness or isolation from social supports.

2. Experiencing difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

3. Exhibiting such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are necessary.

4. Exhibiting difficulty in cognitive ability (such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior).

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Crisis stabilization services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Required Activities

- The program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling. Service may be provided in any of the following settings, but shall not be limited to: (1) the home of an individual who lives with family or another primary caregiver; (2) the home of an individual who lives independently; or (3) community based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

- A face-to-face service-specific provider intake which documents the need for crisis stabilization and the anticipated duration of need must be completed by the LMHP, LMHP Supervisee or Resident, certified pre-screener or a QMHP-A, QMHP-C or QMHP-E prior to the initiation of services.

- If the face-to-face service specific provider intake is performed by a certified pre-screener or a QMHP it must be reviewed and approved by a licensed mental health professional within 72 hours of the service specific provider intake.

- The ISP must be developed or revised by the QMHP, a certified pre-screener, or an LMHP or LMHP Supervisee or Resident within ten (10) business days of service specific provider intake or re-service specific provider intake. The ISP must be cosigned by the individual.

- Services are provided in accordance with the ISP.

- Services are provided by a QMHP-A, QMHP-C, or QMHP-E, an LMHP, LMHP Supervisee or Resident, **or** a Certified Pre-screener.

- Services must be documented through daily notes and a daily log of times spent in the delivery of services.

- If any case management is being provided, there must be coordination with the case management agency.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of this community mental health rehabilitative services.

Limitations

- Room and board, custodial care, and general supervision are not components of this service.

- Service is neither appropriate nor reimbursed for: (1) individuals with medical conditions which require hospital care; (2) individuals with a primary diagnosis of substance abuse; (3) individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to self or others.

- Staff travel time is excluded.

- DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all beds located within the program/facility, regardless of whether or not the services are billed Medicaid. If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart) the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

- Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that

crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

Service Units and Maximum Service Limitations

- A billing unit is one hour.
- There is a limit of eight (8) hours a day for up to **15 consecutive days in each episode,** up to 60 days annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st thereafter, all service limits will be set to zero. The scale year runs July 1 through June 30.
- While service authorization for this service is not required, registration of this service with the BHSA is required effective, April 1, 2014. Providers under contract with the BHSA should contact the BHSA directly for more information.

Mental Health Skill-building Services (H0046)

Service Definition

Mental health skill-building services shall be defined as goal directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS shall include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the individual's health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition. Providers shall be reimbursed only for training activities related to these areas, and only where services meet the revised service definition, service eligibility, and service provision criteria and guidelines as described in the regulations and this manual.

Service Eligibility Criteria

An Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for MHSS services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

For adult members 21 and older an Independent Clinical Assessment is not required.

1. Individuals qualifying for Mental Health Skill-building Services must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized training to achieve or maintain stability and independence in the community.

2. Individuals age 21 and over shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:
    a. The individual shall have one of the following as a primary Axis I DSM diagnosis:
        (1) Schizophrenia or other psychotic disorder as set out in the DSM,
        (2) Major Depressive Disorder – Recurrent;
        (3) Bipolar I; or Bipolar II;
        (4) Any other Axis I mental health disorder that a physician has documented specific to the indentified individual within the past year to include all of the following: (i) that is a serious mental illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community.

    b. The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.

    c. The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization, Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or Temporary Detention Order (TDO) pursuant to the *Code of Virginia* §37.2-809(B) evaluation as a result of decompensation related to serious mental illness. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service.

    d. The individual shall have had a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service.

3. Individuals younger than 21 years of age shall meet all of the above criteria in order to be eligible to receive mental health skill-building services and the following:
    The individual shall be in an independent living situation or actively transitioning into an independent living situation. (If the individual is transitioning into an independent living situation, Services shall only be authorized for up to six months prior to the date of

transition). Independent living situation means a situation in which an individual, younger than 21 years of age, is not living with a parent or guardian or in a supervised setting and is providing his own financial support.

Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance abuse disorder. If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Mental Health Skill-building Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider intake, the ISP, and the progress notes.

Required Activities

For individuals under 21, the provider must maintain a copy of the fully completed Independent Clinical Assessment in each individual's file.

1. The initial face-to-face service specific provider intake (H0032, U8) and the six month re-assessment must be conducted face-to-face by the LMHP or an LMHP Supervisee or Resident. The service specific provider intake may be completed no more than 30 days prior to the initiation of services and must indicate that service needs can best be met through mental health skill-building services.

   Continuation of services may be approved at six-month intervals or following any break in services of more than 30 days by a LMHP or a LMHP Supervisee or Resident based on a service specific provider intake and documentation of continuing need.

   Service authorization is not required to bill for the face-to-face service specific provider intake (Note Chapter V for the service specific provider assessment code and billing instructions). Providers under contract with the BHSA may contact the BHSA for more information.

2. The assessment must be updated annually. Every six months, the LMHP or LMHP Supervisee or Resident must review the individual ISP and services being received in order to determine if a continuation of services is necessary. The LMHP or LMHP Supervisee or Resident must then document the need for the continuation of services by indicating that the individual is continuing to meet eligibility requirements and is making progress towards ISP goals. Though the regulations do not specify that a re-assessment must be completed at this time, it is the responsibility of the LMHP and the provider to ensure that a thorough review of the individual's progress and continuation of need is clearly documented and supported in the documentation with specific examples. Clinically it may be helpful for the LMHP or LMHP Supervisee or Resident to complete a new assessment in order to obtain that information however DMAS does not require that it be done.

3. The LMHP, QMHP-A, or QMHP-C shall complete, sign and date the Individualized Service Plan (ISP) within 30 days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall include the dated signature of the LMHP, QMHP-A, or QMHP-C and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of service.

4. Every three months, the LMHP, QMHP-A or QMHP-C shall review the ISP with the individual, modify as appropriate, and update the ISP. This review shall be documented in the record, as evidenced by the dated signatures of the LMHP, QMHP-A or QMHP-C and the individual. The ISP must be rewritten annually.

5. The ISP shall include discharge goals that will enable the individual to achieve and maintain Community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.

6. Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

7. If the provider knows of or has reason to know of the individual's non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, QMHP-A or QMHP-C shall be informed of any medication regimen non-adherence. The LMHP, QMHP-A or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-adherence concerns. The provider shall document the following minimum elements of the contact between the LMHP, QMHP-A or QMHP-C and the prescribing physician: a. name and title of caller; b. name and title of professional who was called; c. name of organization that the prescribing professional works for; d. date and time of call; e. reason for care coordination call; f. description of medication regimen issue or issues that were discussed; and g. resolution of medication regimen issue or issues that were discussed.

8. The provider shall document evidence of the individual's prior psychiatric services history, as required above under eligibility requirements, by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Family member statements shall not suffice to meet this requirement. The provider shall document the following minimum elements: a. name and title of caller; b. name and title of professional who

was called; c. name of organization that the professional works for; d. date and time of call; e. specific placement provided; f. type of treatment previously provided; g. name of treatment provider; and f. dates of previous treatment.

Providers may use their own records to validate prior history, however they must clearly document in the MHSS note where in the electronic record substantiating information (ex: doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found. If an individual sees a psychiatrist outside of the agency and the medication area of the record is documented to reflect the psychiatric history and prescribed medications, then in that section of the record each of the required elements in the regulation including: the worker who checked the record, what record was viewed and the person who wrote the note that was viewed, the name of the organization that the record belongs to, the date and time the record was reviewed, the specific placement provided, the type of treatment previously provided, the name of the treatment provider, and the dates of the previous treatment must be provided. A MHSS note directing the reader to refer to another section of the individual's medical record with the same provider agency will be accepted as meeting the requirement. Again, it must clearly document in the MHSS note where in the electronic record substantiating information can be found.

9. The provider shall document evidence of the psychiatric medication history, as required by above under eligibility requirements by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy or after obtaining written consent from the individual. The current provider shall document the following minimum elements: a. name and title of caller; b. name and title of prior professional who was called; c. name of organization that the professional works for; d. date and time of call; e. specific prescription confirmed; f. name of prescribing physician; g. name of medication and ; f. date of prescription.

The MHSS regulations outline specific documentation requirements in order to satisfy the criteria for validating medication history. Examples include either photocopies of the prescription information from the bottle or contacting the prior provider. Providers may use their own records to validate medication history (doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date), however they must clearly document in the MHSS note where in the electronic record substantiating information can be found.

10. Only direct face-to-face contacts and services to an individual shall be reimbursable.

11. Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

12. Any services provided to individuals that are strictly vocational in nature shall not qualify for Medicaid reimbursement. However, support activities and activities directly related to

assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

13. Room and board, custodial care, and general supervision are not components of this service and are NOT eligible for Medicaid reimbursement.

14. Provider qualifications. The enrolled provider of mental health skill-building services shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, LMHP Resident/Supervisee, QMHP-A, QMHP-C or QMHPP. The LMHP, QMHP-A or QMHP-C will supervise the care weekly if delivered by the qualified paraprofessional. Documentation of supervision shall be maintained in the MHSS record.

15. Mental health skill-building services, which may continue for up to six consecutive months, must be reviewed and renewed at the end of the period of service authorization by an LMHP who must document the continued need for the services.

16. Mental health skill-building services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.

17. If mental health skill-building is provided in a group home (Level A or B) or assisted living facility the ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

Limitations and Exclusions

1. Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the providers' respective facility. Individuals residing in facilities may, however receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside. **"Affiliated" means any entity or property in which a group home or assisted living facility has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.**

2. MHSS shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS) waivers.

3. MHSS shall not be reimbursed for individuals who are also receiving Independent Living Skills Services, the Department of Social Services (DSS) Independent Living Program, Independent Living Services, or Independent Living Arrangement or any CSA-funded independent living skills programs.

4. Medicaid coverage for MHSS shall not be available to individuals who are receiving Treatment Foster Care.

5. Medicaid coverage for MHSS shall not be available to individuals who reside in ICF/IDs or hospitals.

6. Medicaid coverage for MHSS shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of MHSS.

7. Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Centers – Level C facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.

8. MHSS shall not qualify for Medicaid reimbursement if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the ID Waiver, DD Waiver, the Elderly or Disabled with Consumer Direction Waiver, and the EPSDT services.

9. Medicaid coverage for Mental health skill-building services shall exclude services that are considered to be duplicative of other reimbursed services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, QMHP-A or QMHP-C to avoid duplication of services.

10. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving/ will not qualify for Medicaid coverage for mental health skill-building services unless their physician issues a

signed and dated statement indicating that this service would benefit the individual by enabling them to achieve and maintain community stability and independence.

11. Medicaid coverage for MHSS for individuals with disorders not identified in Axis I, such as personality disorders and other mental health disorders that may lead to chronic disability, will not exclude provided that the individuals have a primary Axis-I DSM diagnosis listed above and the provider can document and describe how the individual is expected to actively participate in and benefit from services, and where the remaining MHSS service criteria and guidelines are satisfied.

12. Academic services are not reimbursable.

13. Vocational services are not reimbursable. Support services and activities directly related to assisting a client to cope with a mental illness in the work environment are reimbursable. Activities that focus on how to perform job functions are not reimbursable.

14. Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.

15. Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.

16. Only direct face-to-face contacts and services to the individual members are reimbursable.

17. Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day
- Three units = 5 to 6.99 hours per day
- Four units = 7+ hours per day

Time may be accumulated to reach a billable unit. Service delivery time must be added consecutively to reach a billable unit of service.

These services may be authorized for up to six consecutive months.

A maximum of 372 units of Mental Health Skill-building Services may be authorized annually with coverage under State Plan Option service. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Mental Health Skill-building Services (H0046) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider's service specific provider intake will continue to be allowed to be billed without service authorization.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement. Providers under contract with the BHSA may contact the BHSA directly for more information.

Substance Abuse Residential Treatment for Pregnant Women (H0018 Modifier HD)

Service Definition

Substance Abuse Residential Treatment for Pregnant Women services are comprehensive and intensive intervention services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Eligibility Criteria

The following criteria must be met for substance abuse treatment:

1) The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2) The woman must be pregnant at admission and intend to complete the pregnancy.

3) The woman must:

    a) Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or

    b) Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or

    c) Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4) The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse

history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

Required Activities

Service specific provider assessments to determine level of need shall use the *American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition, Revised 2001.

The following types of services or activities must be provided:

1. A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic service specific provider assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.

2. Initial and ongoing assessments must be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.

3. Documented on the service specific provider assessment that Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) criteria are met for this service.

4. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

5. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

6. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

7. Personal health care training and assistance, including:
   - Education and referral for testing, counseling, and management of HIV;

   - Education and referral for testing, counseling, and management of tuberculosis; and

- Education and referral for testing, counseling, and management of hepatitis.

8 Case coordination with providers of primary medical care, including obstetrical and gynecological services.

9 Training in decision-making, anger management, and conflict resolution.

10 The ISP must be fully developed by the qualified substance abuse professional within one week after admission, involving the woman, and a representative of the appropriate service agencies. The ISP must be reviewed and updated every two weeks. The ISP must be cosigned by the member.

11 Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.

12 A contractual relationship with a Medicaid enrolled OB/GYN.

13 An obstetric assessment must be completed by and documented within a 30 day period following admission.

14 The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural differences, and counseling.

15 Medical care must be coordinated by a registered nurse case manager. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

16 A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff.

17 Access to services either through staff or contract:

a) Psychiatric assessments, as needed, by a physician licensed by the Virginia Board of Medicine;

b) Psychological assessments, as needed, by a licensed clinical psychologist licensed by the Board of Psychology of the Virginia Dept. of Health Professions;

c) Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist;

d) Medication management, as needed or at least quarterly, by a physician licensed by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate; and

e) Primary health care, if not available through other means including gynecological and obstetrical care.

18 Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.

19 The program director must document the reason for granting any absence in the clinical record of the member.

20 Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.

21 The provider must ensure that individual's have access to emergency services on a 24-hour basis seven days per week, 365 days per year, either directly or via an on-call system.

Limitations

- No reimbursement for any other Community Mental Health Rehabilitative Services is available while the individual is participating in this program.

- Residential capacity shall be limited to 16 adults. No services may be provided to children of mothers in the program.

- The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.

- Days of unauthorized absence cannot be billed.

Service Units and Maximum Service Limitations

- A billing unit is one day.

- There is a limit of 300 days per pregnancy, not to exceed 60 days postpartum that can be used annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

- Unauthorized absence of less than 72 hours is included in this limit.
- An unauthorized absence of more than 72 hours will result in termination of Medicaid reimbursement or retraction of payments already made.

Substance Abuse Day Treatment for Pregnant Women (H0015 Modifier HD)

Service Definition

Substance Abuse Day Treatment for Pregnant Women Services are comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Eligibility Criteria

The following criteria must be met for substance abuse treatment:

1) The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2) The woman must be pregnant at admission and intend to complete the pregnancy.

3) The woman must:

    a) Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or

    b) Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or

    c) Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4) The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

Required Activities

Service specific provider assessments to determine level of need shall use the *American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition, Revised, 2001.

The following types of services or activities must be provided:

1. A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic service specific provider assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.

2. Initial and ongoing assessments must be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.

3. Documented on the service specific provider assessment that Level II.1 (Intensive outpatient Treatment) or II.5 (Partial hospitalization) criteria are met for this service.

4. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

5. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

6. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

7. Personal health care training and assistance, including:
   - Education and referral for testing, counseling, and management of HIV;
   - Education and referral for testing, counseling, and management of tuberculosis; and;
   - Education and referral for testing, counseling, and management of hepatitis.

8. Case coordination with providers of primary medical care, including obstetrical and gynecological services.

9. Training in decision-making, anger management, and conflict resolution.

10. The ISP must be developed by the qualified substance abuse professional within 14 days after admission involving the woman, appropriate significant others, and representatives of appropriate service agencies. The ISP must be reviewed and updated every four weeks. The ISP must be cosigned by the member.

11. Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.

12. A contractual relationship with a Medicaid enrolled OB/GYN.

13. An obstetric assessment must be completed and documented within a 30 days period following admission.

14. The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural variances and counseling.

15. Medical care must be coordinated by a registered nurse case manager. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

16. A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff. The provider shall ensure that recipients have access to emergency services on a 24-hour basis seven days per week, 365 days per year, either directly or via an on-call system.

17. Access to services either through staff or contract:

a) Psychiatric assessments, as needed, by a physician licensed by the Virginia Board of Medicine;

b) Psychological assessments, as needed, by a licensed clinical psychologist licensed by the Board of Psychology of the Virginia Department. of Health Professions;

c) Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist

d) Medication management, as needed or at least quarterly, by a physician licensed by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate; and

e) Primary health care, if not available through other means including gynecological and obstetrical care.

18. Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.

19. The program director must document the reason for granting any absence in the clinical record of the member.

20. Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.

21. The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.

Limitations

- Only mental health crisis intervention services or mental health crisis stabilization may be reimbursed for members of day treatment services.
- More than two episodes of five-day absences from scheduled treatment without prior permission from the program director, or one absence exceeding seven (7) days of scheduled treatment without prior permission from the program director, shall terminate the services.

Services Units and Maximum Service Limitations

- A billing unit is a minimum of two (2) hours but less than four (4) hours.

There is a limit of 400 units per pregnancy, not to exceed 60 days postpartum. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. The fiscal year period is July through June 30.

- One unit = 2 - 3.99 hours
- Two units = 4 - 6.99 hours
- Three units = 7+ hours

Mental Health Case Management (H0023)

A summary of the regulatory changes that affect providers of targeted case management services has been incorporated in this manual. For the entire notice with all provisions, please refer to the Federal Register (Vol. 74, No. 124 FR 31183) at http://edocket.access.gpo.gov/2009/pdf/E9-15345.pdf). CMS retained the following provisions, which went into effect on July 1, 2009.

Service Definition

Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services.

Case management does not include the provision of direct services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Population Definitions

The following Department of Behavioral Health and Developmental Services definitions are referred to in the discussion of the appropriate populations for Mental Health Case Management services.

1. Serious Mental Illness

Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis

There must be a major mental disorder diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy these criteria.

b. Level of Disability

There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:

1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.

2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.

3) Has difficulty establishing or maintaining a personal social support system.

4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness

The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria:

1) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).

2) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

2. Serious Emotional Disturbance

Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM-IV, or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year's time; and

b. Problems that are significantly disabling based upon the social functioning of most children that age; and

c. Problems that have become more disabling over time; and

d. Service needs that require significant intervention by more than one agency.

Children diagnosed with Serious Emotional Disturbance and a co-occurring substance abuse or developmental disability diagnosis are also eligible for Case Management for Serious Emotional Disturbance.

3. At Risk of Serious Emotional Disturbance

Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:

a. The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or

b. Parents, or persons responsible for the child's care, have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

Eligibility Criteria

The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

- There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent.
- The individual must require case management as documented on the ISP, which is developed by a qualified mental health case manager and based on an appropriate service specific provider assessment and supporting documentation.
- To receive case management services, the individual must be an "active client," which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 days.

Required Activities

The following services and activities must be provided:

- A comprehensive service specific provider assessment must be completed by a qualified mental health case manager to determine the need for services. The CM service specific provider assessment is part of the first month of CM service and requires no service authorization.

- Service specific provider assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such).

- This service specific provider assessment then serves as the basis for the ISP.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services, specifically mental health case management.

- The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.

- Linking the individual to needed services and supports specified in the ISP.

- Provide services in accordance with the ISP.

- Coordinating services and treatment planning with other agencies and providers.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

- Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.

- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the

community. These activities must be linked to the goals and objectives on the Case Management ISP.

- Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.

- A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the member's status.

- Case Management services are intended to be an individualized client-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was consumer-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

- The ISP shall be updated at least annually.

Service Units and Maximum Service Limitations

- A billing unit is one calendar month.

- Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the face to face visit, or the date the monthly summary note has been documented, or a specific date service was provided. In order to support the 1 billing unit per calendar month, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. Providers are NOT to span the month for SPO CM services.

- Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one

face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

- Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

- No other type of case management, from any funding source, may be billed concurrently with targeted case management.

- Reimbursement for case management services for individuals age 21-64 in Institutions for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

- There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical facilities. Case management services may not be provided for institutionalized individuals who are age 65 and older and under age 21. Services rendered during the time the individual is not admitted to the IMD may be billed, even if during the same month as the admission to the IMD.

- To bill for case management services for individuals that are in an acute care psychiatric units, two conditions must be met. The services may not duplicate the services of the hospital discharge planner, and the community case management services provided to the individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case management may not be billed when a child is receiving Intensive In-Home Services.

- Case management may not be billed when an individual is open to Intensive Community Treatment.

- Case management services for the same individual must be billed by only ONE type of case management provider. See Chapter V for billing instructions.

While service authorization for this service is not required, registration of this service with the BHSA is required. If the individual qualifies for case management through a different population definition (‘at risk’, SED, or SMI) a new registration is required Providers under contract with the BHSA should contact the BHSA directly for more information.

Case Management Agency Requirements

1. The service specific provider intake and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider intake must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included. The ISP is defined in the "Exhibits" section at the end of this chapter.

6. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Monitoring and Re-Evaluation of The Service Need By The Case Manager

The case manager must continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.

This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the individual and a face-to-face contact with the individual at least once every 90 days.

The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

Substance Abuse Case Management (H0006)

Service Definition

Substance Abuse case management assists children, adults, and their families with accessing needed medical, psychiatric, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs.

If an individual has co-occurring mental health and substance abuse disorders, the case manager shall include activities to address both the mental health and substance use disorders. Only one type of case management may be billed at one time. Please see the Limitations section.

Population Definitions

The Medicaid eligible member shall meet the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence, or tobacco use disorder is not covered.

Eligibility Criteria

There must be documentation of the presence of a substance-related disorder which Meets DSM-criteria.

- The individual must require case management as documented on the ISP, which is developed by a qualified substance abuse case manager at the initiation of services and based on an appropriate service specific provider assessment and supporting documentation.

- To receive case management services, the individual must be an "active client," which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 days. There must be at least one direct or client-related contact every 30 days.

Required Activities

The following services and activities must be provided:

- Service specific provider assessment and planning services, to include developing an ISP (does not include performing service specific provider assessments for severity of substance abuse or dependence, medical, psychological and psychiatric assessment but does include referral for such assessment).

- With the exception of the 30-day period following the initiation of case management services the individual must be receiving another substance abuse treatment service.

- A service specific provider intake must be completed by a qualified substance abuse case manager to determine the need for services. This service specific provider intake then serves as the basis for the ISP.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services.

- The ISP must document the need for case management and be fully completed within 30 days of the initiation of the service. The ISP must be cosigned by the individual receiving services. The case manager must modify the ISP as necessary, review it every three months, and rewrite it annually. The first quarterly review will be due the last day of the third month from the date of the ISP. Each subsequent review will be due by the last day of the third month following the month in which the last review was due and not on the date when the review was actually completed in the grace period. A grace period will be granted up to the last day of the fourth month following the month the review was due.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.

- Linking the individual to services and supports specified in the ISP. When available, service specific provider assessment and evaluation information should be integrated into the Individual Service Plan within two weeks of completion. The Individual Service Plan shall utilize accepted patient placement criteria and shall be fully completed within 30 days of initiation of service.

- Provide services in accordance with the ISP.

- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources.

- Coordinating services and treatment planning with other agencies and providers.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

- Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.

- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.

- Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, substance abuse, or family coping skills are not case management activities.

- A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the individual's status.

Case Management services are intended to be an individualized person-specific activity between the case manager and the individual. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was person-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

Service Units and Maximum Service Limitations

- The billing unit for case management is 15 minutes.

- Billing can be submitted for case management only when direct or client-related contacts, activity, or communications occur.

- Reimbursement is provided only for "active" case management.

- No other type of case management may be billed concurrently with substance abuse case management including mental health, treatment foster care, or services that include case management activities such and Intensive Community Treatment or Intensive In-Home Services.

- Reimbursement for case management services for individuals who reside in an Institution for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness or substance abuse and is greater than 16 beds.

- A claim edit is place that will cut back payment or deny claims for services beyond the maximum number of units allowed. The maximum service limit for substance abuse case management services is 52 hours or 208 units annually. Each July 1st service limits will be set to zero. The fiscal year is from July 1-June 30.

- To bill for case management services, for individuals that are in an acute care psychiatric units, two conditions must be met. The services may not duplicate the services of the institutional discharge planner, and the community case management services provided to the institutionalized individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for institutionalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

Case Management Agency Requirements

- The service specific provider intake and subsequent re-assessments of the individual's medical, mental, substance use, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider assessment must also include current documentation of a medical examination, a psychological/psychiatric/substance abuse evaluation, and a social assessment.

- All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

- There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate a document verifying freedom of choice of providers was offered and this provider was chosen.

- A release form must be completed and include the dated signature of the individual for the release of any information.

- There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for

monitoring, linking, and coordinating must be included. The ISP is defined in the "Exhibits" section at the end of this chapter.

- There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Monitoring and Re-Evaluation of the Service Need By the Case Manager

The case manager must continuously monitor the appropriateness of the member's ISP and make revisions as indicated by the changing support needs of the member. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.

This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the member and a face-to-face contact with the member at least once every 90 days.

The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

Substance Abuse Crisis Intervention (H0050)

Service Definition

Crisis intervention services are substance abuse treatment services, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the member or others; and
- To provide treatment in the least restrictive setting.

Eligibility Criteria

Substance abuse crisis intervention services are provided following a marked reduction in the member's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Crisis Intervention Services.

Required Activities

- A Certified CSB/BHA Pre-screener or Qualified Substance Abuse Professional (QSAP) must complete and document a face-to-face service specific provider intake of the crisis situation; provide short-term counseling to stabilize the individual or family unit; provide access to further immediate assessment and follow-up; and link the individual and family with ongoing care to prevent future crises.

- Services may be provided to eligible individuals outside of the clinic and billed if it is clinically or programmatically appropriate, or both.

- There must be documentation of immediate substance abuse treatment with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.

- Services may include office visits, home visits, telephone contacts, or other client related activities for the prevention of institutionalization.

- <u>The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member's receipt of community mental health rehabilitative services.</u>

- Monitoring and face to face support may be provided by a QSAP, a certified pre-screener, or a paraprofessional to ensure the individual's safety. A paraprofessional must be under the supervision of at least a QSAP and provide services in accordance with a plan of care.

NOTE: Medicaid cannot be billed for substance abuse crisis intervention services for an individual under Emergency Custody Orders (ECOs) or Temporary Detention Orders (TDOs). Services may be billed up to the time an order for TDO or ECO is received. If the ECO ends without a TDO being called, services rendered after the ECO ends may be billed. Documentation of TDOs and ECOs must clearly delineate the separation of time. Refer to the *Hospital* Provider Manual, Appendix B, for further information.

- Staff travel time is excluded from billable time.

- Substance Abuse Crisis intervention services may involve the individual's family or significant others.

- An ISP is not required for newly admitted individuals. Inclusion of the service on the ISP is not required for the service to be provided to an active case on an emergency basis.

- An ISP prepared by a Certified Pre-screener or QSAP by the **fourth** face-to-face contact must be developed or revised to reflect treatment goals and

interventions for scheduled short-term counseling. The ISP must be cosigned by the individual receiving services.

- Services are provided by a Certified Pre-screener ***or*** QSAP.
- If case management is being provided, there must be coordination with the case management agency.
- If other clinic services are billed while the individual is receiving Crisis Intervention services, documentation must clearly support the separation of the services with distinct treatment goals.

Service Units and Maximum Service Limitations

- A unit of service is 15 minutes of Substance Abuse Crisis Intervention. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. A maximum of 720 units of Substance Abuse Crisis Intervention can be provided annually. Each July 1st all service limits will be set to zero.
- The fiscal year period is July 1 through June 30.
- A face-to-face contact with the individual must occur during the crisis episode in order to bill Medicaid for Substance Abuse Crisis Intervention Services. Other contacts, such as telephone calls and collateral contacts during the crisis episode, are reimbursable as long as the requirement for a face-to-face contact is met. Billable contacts which are directed toward crisis resolution for the individual may occur prior to the face-to-face contact.
- Reimbursement will be provided for short-term crisis counseling contacts scheduled within a 30-day period from the time of the first face-to-face crisis contact.

<u>Substance Abuse Intensive Outpatient (H2016)</u>

Service Definition

Substance Abuse Intensive Outpatient Treatment services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours per week. This service should be provided to those individuals who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. The maximum annual limit is 600 hours.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Substance Abuse Intensive Outpatient Treatment Services, individuals must meet the Diagnostic Statistical Manual

diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence or tobacco use alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Intensive Outpatient Services.

Required Activities

- Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider intake and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the individual receiving services.

- Services must be provided in accordance with the ISP.

- Progress notes for Substance Abuse Intensive Outpatient Treatment Services must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a dated staff signature.

- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention,

occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

- The QSAP must supervise the paraprofessional at least twice a month Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the clinical record of the individual receiving services and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the individual's status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two continuous hours in a 24-hour period.

- A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

- Substance Abuse Intensive Outpatient services may not be provided concurrently with substance abuse day treatment services or opioid treatment services.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

- A maximum of 600 hours per year is allowed. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Substance Abuse Day Treatment (H0047)

Service Definition

Substance Abuse Day Treatment services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Substance Abuse Day Treatment Services, individuals must demonstrate a clinical necessity for the service by meeting the Diagnostic Statistical Manual diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence, or tobacco use. A diagnosis of nicotine or caffeine abuse or dependence, or tobacco use alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Day Treatment.

Required Activities

- Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider intake and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the individual receiving services.

- Services must be provided in accordance with the ISP.

- Progress notes for Substance Abuse Day Treatment must be completed when services are delivered. The documentation must include the date of the service,

the service or activity provided, the units provided, the provider rendering the service, and a staff signature.

- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

- The QSAP must supervise the paraprofessional at least twice a month Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the clinical record of the individual receiving services and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented in the clinical record monthly.

- A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when less intensive services may achieve stabilization.

- Substance abuse day treatment may not be provided concurrently with Substance Abuse Intensive Outpatient or opioid treatment services.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

- A maximum of 1,300 hours is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is from July 1 through June 30.

Opioid Treatment (H0020)

Service Definition

Opioid Treatment is provided in daily sessions. The treatment year service limit is 600 hours.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Substance Abuse Opioid Treatment Services, individuals must demonstrate a clinical necessity for the service by meeting the Diagnostic Statistical Manual diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence, or tobacco use disorder alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Opioid Treatment.

Required Activities

- Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider intake and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the individual receiving services.

- Services must be provided in accordance with the ISP.

- Progress notes for Opioid Treatment Services must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a staff signature.

- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

- The QSAP must supervise the paraprofessional at least twice a month Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the clinical record of the individual receiving services and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented in the clinical record monthly.

- A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when less intensive services may achieve stabilization.

- Opioid treatment may not be provided concurrently with Substance Abuse Intensive Outpatient or Substance Abuse Day Treatment services.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.
- A maximum of 600 hours is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year is from July 1 through June 30.
- Providers may submit reimbursement claims for opioids which are administered to persons receiving Opioid Treatment Services. Providers may enroll as a Pharmacy provider (please refer to the Pharmacy Manual) or submit the appropriate Healthcare Common Procedure Coding System (HCPCS) identifier for medication administration.

Pharmacies bill as point of sale. If the drug is provided through a clinic, then the appropriate HCPCS, J-code or S-code would be billed. For example, S0109 indicates 5 mg. of oral methadone. The HCPCS code, J8499 (unclassified non-chemotherapeutic drug, oral administration) may also be used to bill for the opioid drug. Members have the right to appeal and a fair hearing for any service.

Notification Requirements

Whenever an adverse action is taken, the individual receiving services must receive written notification of the pending action at least 10 days before the effective date of the action, except for the following:

1. Advance notice will be reduced to five days if the facts indicate the action is necessary because of probable fraud; and
2. Advance notice does not need to be sent if:
    - The individual has stated in writing that he or she no longer wishes to receive Medicaid services;
    - The individual gives information that requires the termination of Medicaid, and the member knows that this action is the result of giving the information;
    - The individual has been admitted to an institution where he or she is ineligible for services under the Virginia *State Plan for Medical Assistance*;
    - The individual moves to another state and has been determined eligible for Medicaid in the new jurisdiction; or

- The individual's whereabouts are unknown. The agency will determine that the individual's whereabouts are unknown if mail sent to the member is returned as undeliverable.

Service Registration

Any included covered behavioral health (mental health or substance abuse) service that does not require a Service Authorization must be registered with Magellan of Virginia. This registration is a means of notifying Magellan that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should register the start of any new service within two (2) business days of the service start date. A list of services requiring registration is available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx under Behavioral Health Services Administrator.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan include:

(i) the individual's name and Medicaid/FAMIS identification number;

(ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and

(iii) the provider's name and NPI, a provider contact name and phone number, and email address.

Claim payments will be delayed if the registration is not completed.

Care Coordination

DMAS and Magellan of Virginia agree that care coordination has two (2) main goals: 1) to improve the health and wellness of individuals with complex and special needs; and 2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Examples when Magellan may provide care coordination to assist individuals and families include:

• Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management.

• An MCO liaison at Magellan will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care.

• Care coordination with Primary Care Physicians (PCPs).

Qualified Medicare Beneficiaries - Coverage Limitations

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the individual's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-

INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers under contract with the BHSA should contact the BHSA directly for more information.

Qualified Medicare Beneficiaries - Extended Coverage Limitations

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These individuals are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

Providers under contract with the BHSA should contact the BHSA directly for more information.

Client Medical Management (CMM) Program

As described in Chapters I and VI, the Medicaid Program may designate certain individuals to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the individual's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these individuals only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

The mental health services described in this chapter are excluded from the CMM Program, and none of the specific CMM provisions apply to these services. However, mental health providers are encouraged to coordinate treatment with the primary physician whose name appears on the individual's eligibility card as other services and medications are monitored routinely.

EXHIBITS

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Community Services Board/Behavioral Health Authority: _____ Consumer ID# _____

Date: _____ Time: From _____ ☐am ☐pm To_____ ☐am ☐pm
Time under court order: _____ Time not under court order: _____

Emergency Custody Order: ☐Yes ☐No ☐Magistrate Issued ☐ Law Enforcement Issued (Paperless)
Date and Time Executed: _____
Extension: ☐Yes ☐No Reason: _____ (identify facility/medical evaluation/other good cause)
Evaluation: ☐ In-person or ☐ Two-way electronic video and audio
Petitioner _____ Phone:_____
Translator and language: _____ Phone: _____

DISPOSITION ☐Recommitment ☐TDO ☐Voluntary ☐CSU ☐ Safety Plan ☐Release ☐Referral ☐Other _____

HOSPITAL/FACILITY _____ Case/TDO #: _____

Personal Information

First Name: _____ Middle: _____ Last Name: _____ DOB: _____Age: ____

SSN: _____ - _____ - _____ ____M / F_____ _____ _____
(Gender) (Race) (Hispanic Origin) (Height) (Weight) (Hair Color) (Eye Color)

Address: _____
(Street) (City) (State) (Zip Code) (County)

Phone: (___)_____Home/Cell Marital Status: _____ Spouse Name: _____

School Division (If applicable): _____ School Attending: _____Grade: _____ Special Ed.: Y or N

(If under age 18)
Mother: _____ Address: _____ Phone: _____ Home/Cell

Father: _____ Address: _____ Phone: _____ Home/Cell

Legal Custodian ☐ Unknown Name: _____Phone: _____Address:_____
Legal Guardian ☐ Unknown Name: _____Phone: _____Address:_____

Emergency Contact: Name _____Relationship to Person: _____ Phone _____

Address: _____
(Street) (City) (State) (Zip Code) (County)

CSB of Residence: _____

CSB Code: _____Contacted: ☐Yes ☐ No _____
(Name) (Phone)

Employment Status: ☐ Unknown_____ Education Level: (All ages)_____
Employer: _____Phone: _____
Military Status: ☐ Unknown _____Start Year: _____ End Year: _____
SSI ☐Yes ☐ No ☐ Unknown SSDI ☐Yes ☐ No ☐ Unknown

Medicaid: ☐Yes ☐ No ☐ Unknown # _____Subscriber Name: _____

Medicare: ☐Yes ☐ No ☐ Unknown # _____ Part D: ☐Yes ☐No _____Plan

Insurance: ☐Yes ☐ No ☐ Unknown _____
(Name of Company/ Group/Plan/Number)

Local Use

Collateral Sources

☐ Individual Requesting Evaluation ☐ Family/Significant Other/Guardian ☐ Treatment Records
☐ Treating Physician/Psychiatrist ☐ CSB Case Manager or Other Staff ☐ Police/First Responders
☐ CIT Officer ☐ WRAP Plan ☐ Advance Directive ☐ Safety & Support Plan
Is CSA (Comprehensive Services Act) involved with minor? ☐Yes ☐ No ☐ Unknown
Is Department of Social Services involved with individual? ☐Yes ☐ No ☐ Unknown
Comments:_____
_____

Presenting Crisis Situation

Referral Source: _____ Consultation Location: _____
Reason for Referral: _____
_____
_____
_____
Assessment:

Behavioral Health Treatment/Services

Current Outpatient Treatment: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services

☐ Private Provider or ☐ CSB Name: _____ Phone: _____

Case Manager: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Prior Inpatient Treatment: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services

Name/Location of Last Tx facility: _____ Adm. Date: _____Discharge Date: _____

Number of Hospitalizations: _____

Ever in a State facility? ☐ Yes ☐ No Name: _____ Date: _____

Ever in a Crisis Stabilization Unit? ☐ Yes ☐ No Name: _____ Date: _____

Other: _____

☐ WRAP Plan ☐MOT ☐ PACT/ICT ☐ NGRI ☐ Advance Directive ☐ Safety & Support Plan ☐ Group Home
☐ Day Treatment ☐ Prevention Services ☐ In-Home Provider Name: _____ ☐ Other: _____

Substance Abuse Assessment

☐ No current use ☐ No history of use ☐ Refuses to answer

Current use listed below:

Drug Type	Priority	Age 1st Use	Frequency of Use and Amount	Method of Use	Date of Last Use and Amount
	Primary				
	Secondary				
	Tertiary				

History of substance abuse ☐ (Drugs, alcohol, mood altering substances, marijuana, prescription medications, inhalants)

Comment: _____

_____

_____

Have you or anyone else ever felt you had a drug or alcohol problem? ☐ Yes ☐ No

Have you received inpatient or outpatient SA treatment? ☐ Yes ☐ No Maintenance services? ☐ Yes ☐ No

Number of prior episodes of any drug: _____ Detoxification treatment? ☐ Yes ☐ No

Name/Location of last treatment facility: _____ Date of Discharge: _____

	Current withdrawal (Past 24 hours)	**History** of withdrawal
Tremors		
Headaches		
Vomiting (Blood present) ☐ Yes ☐ No		
Nausea		
Diarrhea (Blood present) ☐ Yes ☐ No		
Sweating		
Paranoia		
DT's		
Other		

BAC: _____Time: _____ Lab Results: _____ ☐ Unable to Test

Tobacco use? ☐ Yes ☐ No Type: _____

Pregnant Status: ☐ Yes ☐ No ☐ Unknown Pregnant and using substances? ☐ Yes ☐ No ☐ Unknown

Mental Status Exam

Appearance: ☐ WNL ☐unkempt ☐poor hygiene ☐ tense ☐ rigid

Behavior/Motor Disturbances: ☐ WNL ☐agitated ☐guarded ☐tremor ☐manic ☐impulsive ☐psychomotor retardation ☐ tearful ☐easily startled ☐distracted ☐hysterical ☐ restless

Orientation: ☐ WNL ☐ Disoriented to: ❍time ❍place ❍person ❍situation

Speech: ☐ WNL ☐ pressured ☐ slowed ☐soft ☐loud ☐slurred ☐ incoherent

Mood: ☐ WNL ☐depressed ☐angry ☐hostile ☐euphoric ☐anxious ☐anhedonic ☐withdrawn

Range of Affect: ☐ WNL ☐constricted ☐blunted ☐flat ☐labile ☐inappropriate

Thought Content: ☐ WNL ☐impaired ☐unfocused ☐unreasonable ☐preoccupation ☐delusions ☐thought insertion ☐grandiose ☐ideas of reference ☐paranoid ☐obsessions ☐phobias

Thought Process: ☐ WNL ☐ illogical ☐abstract ☐concrete ☐incoherent ☐ perseverative ☐impaired concentration ☐ loose associations ☐ flight of ideas ☐circumstantial ☐blocking ☐tangential

Sensory: ☐ WNL ☐ illusions ☐ flashbacks ☐ Hallucinations: ❍auditory ❍visual ❍olfactory ❍ tactile

Memory: ☐ WNL ☐ Impaired: ❍ recent ❍ remote ❍ immediate

Appetite: ☐ WNL ☐ increased ☐decreased Weight: ❍ stable ❍ loss ❍ gain

Sleep: ☐ WNL ☐ hypersomnia ☐onset problem ☐ maintenance problem

Insight: ☐ WNL ☐ blaming ☐little ☐ none

Judgement: ☐ WNL ☐ impaired ☐ poor

Estimated Intellectual Functioning: ☐Above average ☐ Average ☐Below average ☐Diagnosed MR ☐Unable to determine

Able to provide historical information: ☐ Yes ☐ No Explain: _____

Reliability of self report ☐ Good ☐ Fair ☐ Poor Explain: _____

Significant Clinical Findings (further describe any symptoms checked above)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical

Primary Care Provider: _____ Phone: _____

Medical history and current medical symptoms or issues:

_____

_____

_____

_____

_____

Medication: **Please see attached medication list** ☐ **Please see attached medical addendum** ☐

Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

	Name	Dose	Schedule	Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Has individual followed recommended medication plan? ☐ Yes ☐ No Explain: _____

Has individual followed recommended recovery plan? ☐ Yes ☐ No N/A ☐ Explain: _____

Recent medication change? ☐ Yes ☐ No ☐ Unknown Date of change: _____

Describe change: _____ _____

Allergies (including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown

Describe: _____

_____

Legal Data

Legal Status: _____ ☐ Unknown

Is individual serving a sentence? ☐ Yes ☐ No ☐ Unknown Details: _____

Is individual NGRI Conditional Release? (Adults only) ☐ Yes ☐ No ☐ Unknown Details: _____

Is individual on probation or parole? ☐ Yes ☐ No ☐ Unknown Contact Person: _____

Pending legal charges? ☐ Yes ☐ No ☐ Unknown Charges: _____

Date of hearing if known: _____ Court of Jurisdiction _____

If a minor: Judge: _____ Attorney: _____ GAL: _____

Has individual come from detention? ☐Yes ☐ No ☐ Unknown

Juvenile Detention Center: _____

(Facility Name) (Address) (Telephone) (Fax)

Diagnosis DSM IV R (P- Provisional, H-Historical)

Axis I _____ Axis I _____ Axis I _____

Axis II _____ Axis II _____

Axis III _____

Axis IV Psychosocial and Environmental (Check all that apply) _____

☐ Support group ☐ Social /Environmental ☐ Educational ☐ Domestic ☐ Occupational ☐ Housing ☐ Economic

☐ Health Care ☐ Legal System ☐ Other _____

Axis V GAF Current: _____ Highest past year, if known: _____

Individual Service Planning

Individuals who may be helpful in treatment planning.

	Name	Telephone	Relationship
1.			
2.			
3.			

☐ Family Member ☐ Guardian Name:_____may be contacted with information that is directly relevant to their involvement with the individual's health care, including location and general condition. (32.1-127.1:03(D34))

☐ Individual agrees ☐ Individual lacks capacity

☐ Individual objects ☐ Emergency makes it practically impossible to agree or object.

Outcome of the emergency evaluation or ECO ☐

No further treatment required, or

☐ Individual declined referral and no involuntary action taken, or ☐

Referred to voluntary crisis stabilization unit, or

☐ Referred to voluntary outpatient or community treatment other than crisis stabilization, or ☐

Referred to voluntary inpatient admission and treatment,

and

☐ Petitioner and ☐ Treating physician notified of disposition if TDO not recommended. ☐

Recommitment recommended by CSB

☐ TDO recommended by CSB

☐ Hearing and commitment process has been explained to the individual.

CSB consulted with magistrate about alternative transportation ☐ Yes ☐ No

☐ CSB does not recommend alternative transportation.

☐ CSB recommends alternative transportation by _____.

(Name)

37.2-805.1

☐ Consideration of 10 day inpatient admission by health care agent pursuant to advance directive _____.

(Name of Agent)

☐ Consideration of 10 day inpatient admission by designated guardian pursuant to guardianship order_____.

(Name of Guardian)

Risk Assessment/Clinical Options

Minor 16.1-340.1

Because of mental illness:

☐ The minor presents a serious danger to ☐self or ☐others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or

☐ Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, as evidenced by: ☐delusional thinking or ☐by a significant impairment of functioning in hydration, nutrition, self protection or self control; and

☐The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.

Findings:_____

_____

The minor's parents/guardians ☐were or ☐were not consulted. The minor's treating or examining physician, if applicable, ☐ was or ☐was not consulted.

Treatment and support options:

Inpatient treatment ☐is or ☐is not the least restrictive alternative that meets the minor's needs ☐

Outpatient or less restrictive services has been tried with the following results:

_____

_____

☐ Outpatient or less restrictive service has *not* been tried and is *not* likely to be adequate because:

_____

_____

Adult 37.2-809

It appears from all evidence readily available that the person:

☐ Has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future:

☐ Cause serious physical harm to ☐ self or ☐ others as evidenced by recent behavior, causing, attempting, or threatening harm, and other relevant information, or,

☐ Suffer serious harm due to his lack of capacity to:

☐protect himself from harm or

☐provide for his basic human needs (not applicable under Virginia Code 19.2-169.6), and

☐ Is in need of hospitalization or treatment.

Findings:_____

_____

Capacity for adults and minors age 14 and older

Able to maintain and communicate choice	☐ Yes	☐ No	Able to understand consequences	☐ Yes	☐ No
Able to understand relevant information	☐ Yes	☐ No	Willing to be treated voluntarily	☐ Yes	☐ No

Risk Factors

☐ Aggressive behavior ☐ Sexual acting out ☐ Self injurious behavior ☐ Elopement ☐ Actively psychotic

☐ Suicidal ideation ☐ Homicidal ideation ☐ Plan ☐ Access to weapons

☐ Other _____

Protective Factors _____

_____

Final Disposition:

_____

_____

_____

_____

_____

_____	_____
Preadmission Screening Evaluator Signature Date Board	Preadmission Screening Evaluator Signature Date Board
Electronically signed ☐	Electronically signed ☐

Name: _____

CSB report to court and recommendations for the individual's placement, care and treatment pursuant to 16.1-340.4 (Minor) or 37.2-816 (Adult)

Name of Individual: _____ Date: _____ Time: _____☐am ☐pm

☐ No further treatment required.

☐ Has or ☐ does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for Outpatient treatment) ☐

Is or ☐ is not willing to be treated voluntarily (* not applicable under Virginia Code19.2-169.6)

☐ Voluntary community treatment at the ☐ CSB (specify) _____

Or ☐ other (specify) _____

☐ Voluntary admission to a crisis stabilization program (specify) _____ ☐

Adult: Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of treatment up to 72 hours and will give the facility 48 hours notice to leave in lieu of involuntary admission.

☐ Minor: Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.

☐ Minor: Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

Minor 16.1-340.4 ☐ Under age 14 ☐ Age 14 or Older

Parent or guardian ☐is or ☐is not willing to consent to voluntary admission (for inpatient treatment only)

☐ **Because of Mental Illness meets the criteria for involuntary admission or mandatory outpatient treatment as follows:**

☐ The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidence by recent acts or threats or: ☐ Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: delusional thinking or significant impairment of functioning in: ☐hydration ☐nutrition ☐self protection ☐ self control. ☐ The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment. Is the parent or guardian with whom the minor resides willing to approve any proposed commitment? ☐ Yes ☐ No ☐ Unavailable

If no, is such treatment necessary to protect the minor's life, health, safety or normal development? ☐ Yes ☐ No

❖**Therefore the CSB recommends:**

A. ☐ Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment.

☐ Alternative transportation

B. ☐ Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and ☐ providers of the services have agreed to deliver the services: The minor, if 14 years of age or older, and his parents or guardians ☐have sufficient capacity to understand the stipulations of the minor's treatment, ☐ have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and ☐ are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and ☐ the ordered treatment can be delivered on an outpatient basis by the Community Services Board or a designated provider(s): specify:_____

C. ☐ Do the best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment? ☐Yes ☐No

Adult 37.2-816

☐ **Because of Mental Illness** meets the criteria for involuntary admission or mandatory outpatient treatment (* not applicable under Virginia Code19.2-169-6)as follows:

☐ There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any, or

☐ There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to lack of capacity:

☐ to protect him/herself from harm or

☐ to provide for his/her basic human needs (* not applicable under Virginia Code19.2-169.6).

❖T**herefore the CSB recommends:**

A. ☐ Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment.

☐ Alternative transportation

B. ☐ Mandatory outpatient treatment (37.2-817 (D))because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐ are deemed to be appropriate; and the person ☐ has agreed to abide by his/her treatment plan, and ☐ has the ability to do so. The recommended treatment ☐ is actually available on an outpatient basis by the ☐ CSB or ☐ designated provider(s) specify: _____.

C. ☐ Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817 (C1) and (C2). ☐The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission ☐ in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; ☐ as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment, and ☐ the person is likely to benefit from mandatory outpatient treatment.

_____ _____

Preadmission Screening Evaluator Signature or Electronically signed ☐ Date Board

_____ _____

Print Name Here (Not required if electronically signed) Representative CSB

Personal Comment Section

As appropriate, the individual receiving emergency services shall be offered the following opportunity to comment at the time of the preliminary evaluation and prior to the commitment hearing. If a minor, the parent or guardian may also comment.

☐ Individual
☐ Parent/Guardian
☐ Family member

☐ Yes (see comments below)
☐ Yes and does not choose to comment
☐ No, Explain: _____

How would you describe the current situation?

_____
_____
_____

Are there things you've already tried to help manage the current situation?

_____
_____
_____

What do you think would be the most helpful to you right now?

_____
_____
_____

If parent/guardian of minor: What do you think would be most helpful to your child right now?

_____
_____
_____

Are there any particular people you would like to be involved in your care and treatment (such as family members, friends, or peers)?

_____
_____
_____

If parent/guardian of minor: Are there particular people you would like to be involved in your child's care and treatment?

_____
_____
_____

What are your top three strengths?

_____
_____
_____

If parent/guardian of minor: What are your child's top three strengths?

_____
_____
_____

Would you like to comment on anything else?

_____
_____
_____

Individual's Signature: _____ Date: _____

Parent/Guardian/Family Member Signature: (if appropriate) _____ Date:_____

SAMPLE FORM

CERTIFICATION OF NEED FOR ADMISSION
TO
RESIDENTIAL PSYCHIATRIC TREATMENT

Child's Name_____

Under each of the three sections below, a child-specific explanation must be provided.

1. Ambulatory/outpatient care does not meet the specific treatment needs of the member:
_____
_____
_____
_____
_____
_____

2. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.
_____
_____
_____
_____
_____

3. The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.
_____
_____
_____
_____
_____

For children who are Medicaid members, this form must be completed and signed by the local CSA interdisciplinary team or FAPT and signed by a physicia 11 nber of the team. The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON. For Non-CSA children, a licensed professional must complete this form.

Team Signatures: _____Date_____ _____Date_____

_____Date_____ _____Date_____

_____Date_____ _____Date_____

Physician Signature: _____ Date: _____

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INITIAL PLAN OF CARE

Name:

Medicaid Number:

Admission Date:

DSM-IV

Axis I
Axis II
Axis III
Axis IV
Axis V

Describe Symptoms, Complaints, and Complications Indicating the Need for Admission to Residential Level of Care (Include problem behaviors 7 days prior to admission)**:**

Functional Level (Medical issues, ability to do activities of daily living)**:**

Long-Term Goal(s) with Measurable Treatment Objectives/Interventions:

1.

2.

3.

Short-Term Goal(s) with Measurable Treatment Objectives/Interventions:

1.

2.

3.

Medications prescribed (note name, dosage and frequency):

Therapies to be provided (type, frequency, duration)

Individual Therapy:

Family Therapy:

Other Therapies (describe):

List the 7 planned therapeutic interventions:

Discharge Plan (including estimated date of discharge):

Team Members Dated Signature (Name, title, handwritten date):

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

Example form for DMAS purposes only. *This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.*

COMPREHENSIVE INDIVIDUAL PLAN OF CARE

Resident Name:

Medicaid Number:

Admission Date:

DSM-IV:

Axis I
Axis II
Axis III
Axis IV
Axis V

Describe the Need for Residential Level of Care (symptoms and behaviors):

Measurable long-term goal(s) with target date for achievement with measurable treatment objectives/interventions:

1. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

Measurable short-term goal(s) with target dates for achievement and each with measurable treatment objectives/interventions (should relate to long-term goals):

1. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

Medications Prescribed (note name, dosage and frequency):

Planned Therapies (note type, frequency, duration):

Individual Therapy:

Family Therapy (if indicated):

Other Therapies (if indicated):

List the 7 planned therapeutic interventions:

Summary of Progress and Justification for Continued Stay (if there is no progress, describe how treatment is being adjusted to address the lack of progress):

Discharge Plan (including estimated date of discharge):

TEAM MEMBERS DATED SIGNATURES

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

DMAS

Example form for DMAS purposes only. *This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.*

COMPREHENSIVE INDIVIDUAL PLAN OF CARE

30-DAY PROGRESS UPDATE

Resident Name:

Medicaid Number:

DSM-IV-Note any changes from the CIPOC:

Axis I
Axis II
Axis III
Axis IV
Axis V

Describe the Continued Need for Residential Level of Care (symptoms and behaviors that cannot be met at a lower level of care):

Describe member's involvement/cooperation in treatment:

LONG-TERM GOAL(S) UPDATE:
Three measurable long-term goals with target dates for achievement and each with measurable treatment objectives/interventions (note if previous goals have been met, and if new goals have been established for unresolved or new problems):

1. _____
MEASUREABLE GOAL

_____
TREATMENT OBJECTIVE/INTERVENTION

_____
TARGET DATE FOR ACHIEVEMENT

2. _____
MEASUREABLE GOAL

_____
TREATMENT OBJECTIVE/INTERVENTION

_____
TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

SHORT-TERM GOAL(S) UPDATE:

Measurable short-term goal(s) with target dates for achievement and each with measurable treatment objectives/interventions (note if previous goals have been met, and if new goals have been established):

1. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

Note Changes to Medications (note name, dosage and frequency):

Individual Therapy (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not):

Family Therapy (as applicable) (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not):

Group Therapy (as applicable)

List any changes to the 7 therapeutic interventions:

Summary of Progress and Justification for Continued Stay (if there is no progress, describe how treatment is being adjusted to address the lack of progress. If new problems have arisen, describe them and how the treatment plan will address them):

Note Changes to Discharge Plan (including estimated date of discharge):

TEAM MEMBERS DATED SIGNATURES

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

Example form for DMAS purposes only. This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.

Individualized Service Plan (ISP) Guide

Statement of Principle: A comprehensive assessment and an Individualized Service Plan (ISP) are the foundation of services designed specifically for a person.

I. Assessments of Person

A. Face-to-face assessments will be conducted to identify a person's physical, emotional, behavioral, and social strengths, preferences, and needs, as applicable.
B. Assessments will be performed prior to development of the ISP.

II. Plan for Service

A. An ISP defines and describes the goals, objectives, and expected outcomes of service(s).
B. The person's needs and preferences will be considered when the service plan is developed and revised.
C. The person and principle service provider or service team are documented participants in service planning.
D. Involvement of the family, guardian, or others in developing the ISP will be consistent with laws protecting confidentiality, privacy, and the rights of minors.

III. ISP - Minimum Required Elements

The ISP will include, at a minimum:

A. A summary or reference to the assessment;
B. Goals and measurable objectives for addressing each identified need;
C. The services, supports, and frequency of service to accomplish the goals and objectives;
D. Target dates for accomplishment of goals and objectives;
E. Estimated duration of service;
F. The role of other agencies if the plan is a shared responsibility; and
G. The staff responsible for coordination and integration of services, including the persons of other agencies if the plan is a shared responsibility.

IV. Progress Notes or Other Documentation

Signed and dated progress notes or other documentation will be used to document the services provided, and the implementation and outcomes of service plans.

V. Services Plan Reviews

Service plans will be reviewed as required for each specific service or at least every six months with goals and objectives updated, if indicated. Reviews will be conducted with the person and in consultation with other service providers and will be signed and dated by the person responsible for the coordination and integration of services.

90-HOUR TRAINING PROGRAM
FOR
PARA-PROFESSIONAL STAFF

Introduction

Completion of this training program will result in qualifying Para-Professionals as providers for Mental Health Rehabilitative Services. Programs of independent study must be documented and verified. Personnel records will document the overall successful completion of the employee's individual training program. Providers will either indicate that this model will be used or will submit an alternative model to DMAS.

Core Areas of Training:

1) Orientation to Organization, Structure, Function and Services of the BHA of employment. 8 hours

2) CPR and First-Aid. 8 hours

3) Management of Aggressive Behavior. 8 hours

4) Universal Precautions/Blood Borne Pathogens, Other Health Related Concerns. 4 hours

5) Relationships, Boundaries and Ethics: Professional Conduct and Behavior, Confidentiality. 8 hours

6) Working in the Larger Community: Resources and Referral Sources, Collaboration with Other Professionals, Using Self-Help and Advocacy Groups, Family Contacts. 4 hours

7) Basic Introduction to Psychopathology and Mental Illness Classification. 8 hours

8) Principles and Practices of the Primary Service Area of Employment: Psychosocial Rehabilitation, Support Services, Therapeutic Day Treatment for Children and Adolescents, and Day Treatment/Partial Hospitalization. Staff are required to complete this core element for each service in which they will work as a service provider. 8 hours each service area.

9) Unique Characteristics of the Work Environment: Age Specific, Physical Disabilities, Ethnic, and/or Cultural Issues of the Program's Participants. 4 hours

10) The ISP, Service Documentation and Review. 8 hours

11) Managing the Unexpected: Emergencies and Crisis Intervention, Insuring the Safety of Self and Others. 4 hours

12) Psychotropic Medications and Side Effects. 4 hours

13) Provider Specific Independent Study of Disorders, Service Populations and Programs. 14 hours (This training component will allow providers to add other elements unique to their system or necessary for the individual's successful performance. Videotapes, assigned readings, and written reports can be used.)

Mental Health Services																										
Service Types	Intensive In Home (H2012)	Therapeutic Day Treatment (H0035HA)	Day Treatment / Partial Hospitalization (H0035HB)	Psychosocial Rehabilitation (H2017)	Intensive Community Treatment (H0039)	Mental Health Support (H0046)	Mental Health Case Management (H0023)	Crisis Intervention (H0036)	Crisis Stabilization (H2019)	SA Day Treatment for Pregnant Women (H0015HD)	SA Residential Treatment for Pregnant Women (H0018HD)	SA Crisis Intervention (H0050HQ, HO)	SA Intensive Outpatient (H2016HM, HN,HO)	SA Day Treatment (H0047HM, HN,HO)	SA Case Management (H0006HO)	Opioid Treatment (H0020)	Out Patient Psy & SA services	Resi Level A, B	TFCM T1016	Resi Level C						
Intensive In-Home Services for Children and Adolescents (H2012)			X		X	X	X		X		X				X			X	X	X						
Therapeutic Day Treatment for Children and adolescents (H0035HA)			X	X	X				X		X									X						
Day Treatment/Partial Hospitalization (H0035 Modifier HB)	X	X									X							X	X	X						
Psychosocial Rehabilitation (H2017)		X									X							X	X	X						
Intensive Community Treatment (H0039)	X	X	X			X	X		X	X	X	X	X	X	X		X	X	X	X						
Mental Health Support (H0046)	X				X				X		X							X	X	X						

Service Types	Intensive In Home (H2012)	Therapeutic Day Treatment (H0035HA)	Day Treatment / Partial Hospitalization (H0035HB)	Psychosocial Rehabilitation (H2017)	Intensive Community Treatment (H0039)	Mental Health Support (H0046)	Mental Health Case Management (H0023)	Crisis Intervention (H0036)	Crisis Stabilization (H2019)	SA Day Treatment for Pregnant Women (H0015HD)	SA Residential Treatment for Pregnant Women (H0018HD)	SA Crisis Intervention (H0050HQ, HO)	SA Intensive Outpatient (H2016HM, HN,HO)	SA Day Treatment (H0047HM, HN,HO)	SA Case Management (H0006HO)	Opioid Treatment (H0020)	Out Patient Psy & SA services	Resi Level A, B	TFCM T1016	Resi Level C						
Mental Health Case Management (H0023)	X				X										X				X	X						
Crisis Intervention (H0036)												X								X						
Crisis Stabilization (H2019)	X	X			X	X					X						X	X		X						
SA Day Treatment for Pregnant Women (H0015HD)					X						X		X	X				X	X	X						
SA Residential Treatment for Pregnant Women (H0018HD)	X	X	X	X	X	X			X	X			X	X		X		X	X	X						
SA Crisis Intervention (H0050HQ, HO)					X			X												X						
SA Intensive Outpatient (H2016HM, HN,HO)					X					X	X			X						X						

Service Types	Intensive In Home (H2012)	Therapeutic Day Treatment (H0035HA)	Day Treatment / Partial Hospitalization (H0035HB)	Psychosocial Rehabilitation (H2017)	Intensive Community Treatment (H0039)	Mental Health Support (H0046)	Mental Health Case Management (H0023)	Crisis Intervention (H0036)	Crisis Stabilization (H2019)	SA Day Treatment for Pregnant Women (H0015HD)	SA Residential Treatment for Pregnant Women (H0018HD)	SA Crisis Intervention (H0050HQ, HO)	SA Intensive Outpatient (H2016HM, HN,HO)	SA Day Treatment (H0047HM, HN,HO)	SA Case Management (H0006HO)	Opioid Treatment (H0020)	Out Patient Psy & SA services	Resi Level A, B	TFCM T1016	Resi Level C						
SA Day Treatment (H0047HM, HN,HO)					X					X	X		X							X						
SA Case Management (H0006HO)	X				X		X												X	X						
Opioid Treatment (H0020)											X									X						
Resi Level A, B	X		X	X	X	X			X		X								X	X						
TFCM T1016	X			X	X		X			X	X				X					X						
Resi Level C	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X								
Out Patient Psy & SA					X				X											X						

X and shading indicates CMHRS that may not be clinically appropriate when provided concurrently and/or by two providers